NHPCare HMO Plan for GIC Members

Neighborhood Health Plan

Member Handbook

Exclusively for Members of the Group Insurance Commission

Neighborhood Health Plan | Group Insurance Commission Member Handbook
Issued and Effective July 1, 2008

Neighborhood Health Plan

www.nhp.org

Deborah Enos
President and Chief Executive Officer

Paul Mendis, MD
Chief Medical Officer

Translation Services

[English]
NHP Member Services staff speak several languages. In addition, NHP will provide Members, upon request, interpreter and translation services related to administrative procedures. Please call NHP Member Services at 800-462-5449 or TTY 800-655-1761 for help.

[Spanish]
Las personas que trabajan en el Departamento de Servicios para Miembros hablan varios idiomas. Además, NHP le ofrece, si usted así lo desea, servicios de intérprete y traducción en el área de servicios administrativos. Para ayuda o información, por favor llame al Departamento de Servicios para Miembros de NHP, por el teléfono 800-462-5449, TTY 800-655-1761.

[French]
Le personnel du service membres NHP parle plusieurs langues. De plus, NHP fournira aux membres, sur simple demande, des services d'interprétation et de traduction en rapport avec les procédures administratives. Veuillez contacter NHP Member Services au 800-462-5449, TTY 800-655-1761 pour assistance.

[Haitian-Creole]
Fonksyonè nan depatman sèvis kliyan NHP yo pale plizyè lang. Apadesa, depi manmb yo mande, NHP ap bay manmb yo entèprèt ak sèvis tradiksyon pou sèvis ki gen rapò ak kòman konpayi an fè zafè li. Tanpri rele NHP Member Services nan 800-462-5449, 800-655-1761 pou èd.

[Portuguese]
Os funcionários do departamento de serviços para os asociados falam varias línguas. Além disso, NHP irá providenciar para seus asociados, quando solicidado, serviços de interpretação e tradução para procedimentos administrativos. Por favor ligue para NHP Member Services no número 800-462-5449, TTY 800-655-1761 para obter ajuda.

[Italian]
Gli incaricati di NHP per il servizio ai membri parlano molte lingue. In aggiunto, NHP puo' provvedere ai suoi membri su richiesta servizio di interprete e di traduzione per le pratiche relative a procedure amministrative. Vi preghiamo di contattare il servizio per i membri di NHP al numero 800-462-5449, 800-655-1761 per informazioni ed aiuto.

[Russian]
Работники отдела по обслуживанию клиентов NHP владеют разными языками. NHP также предоставляет своим клиентам, по их просьбе, услуги по письменному и устному переводу, связанные с административными вопросами. Вы можете получить помощь в отделе по обслуживанию клиентов NHP (NHP Member Services) по телефону: 1-800-462-5449.

[Lao]
ພະນັກງານບໍລິການລູກຄ້າ NHP ສາມາດເວົ້າຫຼາຍພາສາ. ນອກຈາກນັ້ນ, ທາງ NHP ຈະສະໜອງການບໍລິການດ້ານການແປພາສາ ແລະ ການແປເອກະສານ ທີ່ກ່ຽວຂ້ອງກັບຂັ້ນຕອນການບໍລິຫານ ຕາມການຮ້ອງຂໍ. ກະລຸນາໂທຫາ NHP Member Services ທາງເລກໄ 800-462-5449, TTY 1-800-655-1761 ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ.

[Greek]

ΤΟ ΠΡΟΣΩΠΙΚΟ ΤΩΝ NHP MEMBER SERVICES ΟΜΙΛΕΙ ΠΟΛΛΕΣ
ΓΛΩΣΣΕΣ. ΕΓΙΝΕ ΠΡΟΣΘΕΤΑ, ΤΟ NHP ΜΠΟΡΕΙ ΝΑ ΠΑΡΕΧΕΙ, ΚΑΤΟΠΙΝ
ΑΙΤΗΣΗΣ, ΣΕ ΑΜΕΣΗ ΤΟΥ ΥΠΗΡΕΣΙΕΣ ΕΞ ΔΙΕΡΜΗΝΕΙΑΣ ΚΑΙ ΜΕΤΑΦΡΑΣΗΣ
ΣΧΕΤΙΖΟΜΕΝΕΣ ΜΕ ΔΙΟΙΚΗΤΙΚΕΣ ΔΙΑΔΙΚΑΣΙΕΣ ΠΑΡΑΚΑΛΟΥΜΕ
ΕΠΙΚΟΙΝΩΝΗΣΤΕ ΓΙΑ ΒΟΗΘΕΙΑ ΜΕ ΤΟ NHP MEMBER SERVICES
ΣΤΟ ΤΗΛΕΦΩΝΟ 1-800-462-5449

[Khmer]

ក្រុមហ៊ុន NHP មានបុគ្គលិកធ្វើការបម្រើសាមាជិកដែលចេះនិយាយបីបួនភាសា។ ចំនែកពីលើនេះ, នៅពេលដែលសាមាជិកស្នើសុំឲ្យមានអ្នកជំនួយផ្នែកខាងភាសានោះ ក្រុមហ៊ុន NHP នឹងផ្តល់ជូនអ្នកបកប្រែទោះខាងការនិយាយក្តីឬខាងការសរសេរក្តី ដើម្បីឲ្យជួយក្នុងរឿងដែលទាក់ទងទៅផ្តល់កិច្ចចាត់ការជាដូចទៅ។ សូមធ្វើការទាក់ទងមក NHP Member Services នៅលេខទូរស័ព្ទ ១-៨០០-៤៦២-៥៤៤៩ សម្រាប់ការស្នើសុំជំនួយផ្សេងៗ។

[Arabic]

تتكلم هيئة خدمات الأعضاء التابعة لـ NHP عدة لغات. بالاضافة، ستوفر NHP للأعضاء، عند الطلب، خدمات الترجمة الشفهية والخطية بما يتعلق بالاجراءات الادارية. يرجى الاتصال بـ NHP Member Services على الرقم 1-800-462-5449 للحصول على المساعدة.

[Chinese]

NHP會員服務部的職員能講數種語言，NHP還能應會員的要求提供與行政程序有關的傳譯和翻譯服務。欲獲得有關幫助，請致電NHP Member Services：1-800-462-5449。

Your Neighborhood Health Plan (NHP) Member Handbook

For Group Insurance Commission (GIC) Members

Welcome to Neighborhood Health Plan (NHP).

NHP is a not-for-profit Managed Care Organization (MCO) based in Massachusetts. We are pleased to have you as a Member, and look forward to working with you and your Primary Care Provider to keep you healthy.

Any time you need assistance understanding your NHP benefits or membership, call our Customer Care Center at 800-462-5449 (TTY 800-655-1761). Our hours of operation are 8:30AM to 6:00PM Monday through Friday.

This handbook contains important information about your NHP benefits. It also contains some technical terms you may be unfamiliar with. If you need help understanding this handbook, NHP Customer Care Representatives are available to help you. NHP also provides Members with free translation services.

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Your NHPCare HMO Summary of Benefitsfor Group Insurance Commission (GIC) Members

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Your NHP Covered Healthcare Services

Your NHPCare HMO Summary of Benefits

The following is a Summary of Benefits available to you. This list is only a summary of the Coverage provided by the plan. Be sure to read the complete explanation found in the section called "Covered Health Care Services," which describes each Member's Coverage in more detail and important information about requirements for, and any limitations of, Coverage.

These benefits are covered when Medically Necessary, authorized by Neighborhood Health Plan (NHP), ordered by your Primary Care Provider (PCP), and provided by an NHP Participating Provider. Outpatient surgery has a separate Copayment schedule of $100 per occurrence with a cap of 4 Copayments per calendar year. Inpatient Hospital admissions have a Copayment of $250 per admission with a cap of 4 Copayments per calendar year.

Copayment will be waived for re-admission to a hospital for any reason if the re-admission occurs within 30 days of release from a hospital (waiver is not automatic and is contingent upon notification to NHP of the re-admission). Members should keep receipts for all visits and Copayments. Contact the NHP Customer Care department at 1-800-462-5449 (TTY 1-800-655-1761) about reimbursement if Copayments were made after the maximum was reached.

Primary Care and Specialty Providers are assigned to different copayment "Tiers." For an explanation of Provider Tiering, please refer to pages 26 and 28 of this member handbook or refer to the Glossary section of this Handbook.

Coverage/Benefit	*Copayments* *****Tier 1 (Excellent) / **Tier 2 (Good) / *Tier 3 (Standard)**
All Primary Care Provider Visits/ Services Performed by Primary Care Provider *Per visit*	$10 / $20 / $25
Urgent and Emergency Medical Care At NHP Primary Care Site *Per visit*	*Same as Primary Care Copayment for Your Primary Care Provider*
Emergency Room Treatment *Per visit, unless admitted to hospital*	$75

ACUTE INPATIENT MEDICAL CARE

All Drugs	$0
Anesthesia	$0
ICU and CCU	$0
Nursing Care	$0
Physician Care	$0
Private Room *Private room must be determined medically necessary and authorized by NHP*	$250*
Radiation Therapy	$0
Semi-Private Room	$250*
Surgery	$0

X-rays and Lab Services $0

SKILLED NURSING FACILITY OR REHABILITATION HOSPITAL CARE

Inpatient Care-Skilled Nursing Facility $0
Up to 100 Days/Calendar Year

Inpatient Care-Rehabilitation Hospital $250*

MATERNITY CARE

Prenatal Care, Exams, Tests ..... $15 / $25 / $35
OB/GYN; Up to 100 Days/Calendar Year

Hospital and Delivery Services $250*

Newborn Care $0

Postnatal Care (OB/GYN) ..... $15 / $25 / $35
Up to 100 Days/Calendar Year

MENTAL HEALTH/SUBSTANCE ABUSE CARE

Outpatient Mental Health
Out of pocket maximum $1,000 per individual/$2,000 per family

Evaluation, Diagnosis, Treatment, Crisis Intervention, and Referral Services By a Qualified Psychiatric Professional $10
Per visit

Outpatient Psychological Testing $10
Per visit

Outpatient Alcohol/Substance Abuse Detox $10
Per visit

Intermediate Mental Health & Substance Abuse Services

Partial Hospitalization, Community Based Acute Treatment, Community Based Detoxification $0
(see page 55 for additional details)

Inpatient Mental Health

Psychiatric Care (Acute Care Hospital) $0

Inpatient Care (Psychiatric Hospital) $0

Inpatient Care (Substance Abuse Treatment Facility) $0

Inpatient Alcohol and/or Substance Abuse Detox $0

OUTPATIENT HEALTHCARE SERVICES

Allergy Treatment $0

Cardiac Rehabilitation Program $0

Early Intervention Services $0
Up to age three: $5,200/calendar year; $15,600 aggregate benefit over total enrollment period

Eye Examinations ..... *Same as Primary Care Copayment for Your Primary Care Provider*
Once every 24 months | Per visit

Family Planning Services *$25*
Per visit

Infertility Services ..... $25 / $100 / $250*
$25 Office / $100 Outpatient / $250 Inpatient, per admission*

Immunizations / Vaccinations $0

Isotope, Radium, radon, or X-ray Therapy ..... (See *Radiation Therapy*)

Laboratory Tests, Diagnostic X-rays $0

Office Visits ..... (See *Primary Care Provider Visits*)
Per visit

Outpatient Surgery $100
Per service; cap of four (4) Copayments/Calendar Year

Physician Visits (Home or Office) ..... *Same as Primary Care Copayment for Your Primary Care Provider*

Preventive Health Care (Adult) ..... *Same as Primary Care Copayment for Your Primary Care Provider*

Radiation Therapy $0
Isotope, Radium, Radon or X-ray Therapy in lieu of surgery for malignancy

Short-Term Rehabilitative Care, Occupational and Physical Therapy $25
Up to 90 days per acute episode

Specialty Care and Consultants $25

Speech Therapy $25

Well-Child Care (Exams and Tests) ..... *Same as Primary Care Copayment for Your Primary Care Provider*

Select Specialty Care

Cardiology ..... $15 / $25 / $35

Endocrinology ..... $15 / $25 / $35

Gastroenterology ..... $15 / $25 / $35

OB/GYN ..... $15 / $25 / $35

All Other Specialty Care $25

DENTAL CARE

Benefits are provided for the dental services listed above only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.

Initial Emergency Treatment (within 72 hours of injury) ..... $25 / $100 / $250*
Including reduction of fractures & removal of cysts or tumors; Copayment based upon place of service

Removal of 7 or More Permanent Teeth ..... $100 / $250*

Excision of Radicular Cysts (involving roots of 3 or more teeth) ..... $100 / $250*

Gingivectomies of 2 or More Gum Quadrants ..... $100 / $250*

Extraction of Impacted Teeth ..... $100 / $250*
*$100 for Surgical Day Care Services or $250 for Hospital Inpatient Care (*limited to 4 Copayments/calendar year)*

DRUGS AND OVER-THE-COUNTER MEDICATIONS

Prescription Drugs (30-Day Supply) ..... $10 / $25 / $45
$10 Generic / $25 Brand Name Preferred / $45 Brand Name Non-Preferred

Prescription Mail Service (3-Month Supply) ..... $20 / $50 / $135
$20 Generic / $50 Brand Name Preferred / $135 Brand Name Non-Preferred

Select OTC (over-the-counter) Medicines ..... $0-$45
With valid prescription from an NHP Provider

Select Diabetic Drugs, Supplies (30-day Supply) ..... $10 / $25 / $45
$10 Generic / $25 Brand Name Preferred / $45 Brand Name Non-Preferred

HOME HEALTH CARE

Skilled Nursing Visits $0

Physical Therapy $0
No charge when patient is receiving home care

Physician House Call ..... *Same as Primary Care Copayment for Your Primary Care Provider*
Per Visit

Durable Medical Equipment $0
No charge when patient is receiving home care

OTHER SERVICES

Prosthesis $0

Ambulance Services $0

Bone Marrow Transplant ..... $100 / $250*
*$100 for Surgical Day Care Services or $250 for Hospital Inpatient Care (*limited to 4 Copayments/calendar year)*

Medically Necessary Durable Medical Equipment ..... $0 / 20%
20% of purchase price or monthly rental cost

Health Education Programs $0

Hearing Aids ..... $0 / 20%
No charge up to first $500; 20% of purchase price of the next $1,500. Maximum benefit per person $1,700 per two-year period

Hospice $0

Human Organ Transplant ..... $100 / $250*
*$100 for Surgical Day Care Services or $250 for Hospital Inpatient Care (*limited to 4 Copayments/calendar year)*

Kidney Dialysis / Hemodialysis $0

Second Opinions *$25*

Orthotics (other than foot orthotics) $0

Oxygen Therapy $0

**Per admission, with a cap of four (4) Copayments per calendar year. Copayment will be waived for re-admission to a hospital for any reason if the re-admission occurs within 30 days of release from a hospital. The hospital inpatient Copayment is not automatic. You must contact NHP to have the Copayment waived.*

Section 1.
Your NHP Evidence of Coverage

Your Neighborhood Health Plan Member Handbook and Benefit Summary represent your complete Evidence of Coverage.

Upon enrollment, NHP will send you, as the Subscriber, an Evidence of Coverage. If NHP changes any Covered Health Care Service, your financial obligations for coverage, or makes any material change to your Evidence of Coverage, we will send you prior notice at least 60 days in advance of the change. Unless required by law, such modifications will be made only with the agreement of the GIC.

NHP will do this by sending you an amendment to your Evidence of Coverage and ask that you keep it with this Member Handbook.

Words with Special Meaning

Some words in this Member Handbook have special meaning. These words will be capitalized throughout the Handbook, and defined in the glossary at the end of the Handbook. For the purposes of this Member Handbook, the word "you" means "Members of NHP."

The NHP GIC Provider Directory

At the time of enrollment, NHP makes available a Provider Directory to new Members. NHP also provides a directory to prospective or current Members upon request. The NHP GIC Provider Directory lists Primary Care Sites, Primary Care Providers, Hospitals, NHP-affiliated Specialists, and Mental Health and Substance Abuse Care Providers in the NHP Network.

To request a copy of the Provider Directory, call Customer Care at 800-462-5449 (TTY 800-655-1761), or visit our Web site at www.nhp.org for the most up to date listing of Providers in your plan.

Information About NHP Providers

Additional information about physicians licensed to practice in Massachusetts is available from the Board of Registration in Medicine. Visit www.massmedboard.org to find information on your physician's education, hospital affiliations, board certification status and more. The following Web sites also provide useful information in selecting quality healthcare Providers:

- ***Leapfrog: www.leapfroggroup.org*** *(for information on healthcare quality, so you can compare hospitals)*
- ***Massachusetts Quality Health Partners:*** *(to learn how different medical groups treat the same type of illness, allowing you to make comparisons)*
- ***Joint Commission for the Accreditation of Healthcare Organizations (JCAHO):*** *www.qualitycheck.org (for information that allows you to compare quality of care at many hospitals, homecare agencies, laboratories, nursing homes, and behavioral health programs).*

For information about Neighborhood Health Plan you may contact the Office of Patient Protection (OPP) at any time by telephone at 1-800-436-7757, by fax at 1-617-624-5046, or on the internet at www.state.ma.us/dph/opp. The following information is available to you from the OPP:

- *A list of sources of independently published information assessing insureds' satisfaction*

and evaluating the quality of Covered Health Care Services offered by NHP;

- *The percentage of physicians who voluntarily and involuntarily terminated participation contracts with NHP during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;*
- *The percentage of premium revenue expended by NHP for health care services provided to Insureds for the most recent year for which information is available;*
- *A report detailing, for the previous calendar year, the total number of filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and, external Grievances pursued after exhausting the internal Grievance process and the resolution of all such external Grievances.*

NHP's Customer Care Center

Whenever you have a question or concern about your NHP membership or benefits, our highly trained Customer Care Representatives are available to help you.

Just call 800-462-5449 (TTY 800-655-1761) and a representative will assist you. Our hours of operation are 8:30 A.M. to 6:00 P.M., Monday through Friday.

Section 2.
Eligibility and Enrollment

Enrollment

There is no waiting period, pre-existing condition limitation, or exclusion under your plan with NHP. NHP does not use the results of genetic testing in making any decisions about enrollment, renewal, payment or coverage of health care services nor does NHP consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making such decisions. NHP will accept you into our plan regardless of your income, physical or mental condition, age, gender, sexual orientation, religion, physical or mental disability, ethnicity or race, previous status as a Member, pre-existing conditions, occupation, claims experience, duration of medical coverage, and/or expected health status. Upon notification of your Enrollment, NHP will mail you a Member ID Card which indicates the Effective Date of your Enrollment with NHP. NHP is not responsible for any services you receive prior to your Effective Date of Enrollment with NHP.

Your NHP Member Card

NHP will mail you a permanent NHP Member Identification Card (NHP Member ID Card) within fifteen (15) calendar days of Enrollment. Your NHP Member ID Card has important information about you and your benefits. It also tells Providers and pharmacists that you are a Member of NHP and how much your Copayment for services should be. Be sure to show your NHP Member ID Card whenever you get health care or fill a prescription. Always carry your Member card with you so it will be handy when you need care. Please read your card carefully to make sure all the information is correct. If you have questions or concerns about your NHP Member ID Card, or if you lose it, call our Customer Care Center at 800-462-5449 or TTY 800-655-1761. Do not allow anyone else to use your NHP Member ID Card for any purpose, including obtaining health care services.

The NHP Service Area

County	*City/Town*
Bristol	Entire County
Essex	Entire County
Hampden	Entire County
Middlesex	Entire County
Norfolk	Entire County
Plymouth	Abington, Bridgewater, Brockton, East Bridgewater, Hanover, Hingham, Hull, Marshfield, Mattapoisett, Norwell, Rochester, Rockland, Scituate, West Bridgewater and Whitman
Suffolk	Entire County
Worcester	Entire County

The NHP Service Area

As an Eligible Individual, you may enroll in NHP if you reside within the NHP service area. As an Eligible Employee, you may enroll in NHP if you are actively working for an employer who is based in the NHP service area and are enrolling in NHP through your employer's group plan. NHP's Service Area includes most communities in Massachusetts (see list above).

Eligibility

Individuals are accepted for Enrollment and continuing Coverage only if they meet all applicable eligibility requirements as set forth below. In addition, individuals must satisfy any eligibility requirements imposed by the Group Insurance Commission. The GIC may require the Subscriber to furnish evidence satisfactory to the GIC on any family Member's eligibility, such as a marriage certificate, birth certificate, a court order for support or a divorce decree.

Subscriber Eligibility

To be eligible to enroll as a Subscriber, a person must:

1. *Be an employee of the Commonwealth of Massachusetts entitled on his/her own behalf (and not as a Dependent) to receive Coverage under the Group Insurance Commission's health benefit plan, OR be a retiree of the Commonwealth of Massachusetts entitled on his/her own behalf (and not as a Dependent) to receive Coverage under the Group Insurance Commission's health benefit plan and not be enrolled in Medicare. To be a Subscriber to NHP, you must be an employee of the Commonwealth of Massachusetts as indicated above, in accordance with employee eligibility guidelines authorized by the GIC and NHP. This includes GIC's up-to-date payment of applicable premium for Coverage.*

2. *To be eligible for Coverage by NHP, you must live, and have a permanent residence in certain areas of Massachusetts (see NHP Service Area in the glossary section of this Handbook), at least nine months of a year to be eligible. Coverage will begin on the first day of the month following 60 days of employment or two calendar months, whichever is less. This residency requirement does not apply to a Dependent Child who is enrolled as a full-time student attending an accredited educational institution. Employees who do not choose to join a health plan when first eligible must wait until the next annual enrollment period to join.*

Eligibility Rules for Dependents

Please see your GIC Benefits Coordinator for specific Dependent eligibility requirements as agreed upon by the GIC and NHP. To be eligible to enroll as a Dependent, a person must be:

1. *The employee's spouse (wife or husband) or surviving spouse (until remarriage) or a divorced spouse who is eligible for Dependent Coverage pursuant to Massachusetts General Laws Chapter 32A; or*

2. *The former spouse of the Subscriber, until the Subscriber or the former spouse remarries or until such time as may be specified in the divorce judgment consistent with state law, whichever occurs first; or*

3. *The child of an eligible Dependent of the Subscriber until such time as the parent is no longer an eligible dependent as determined by the GIC.*

4. *A child of the employee or the employee's spouse, by birth, legal adoption (including a child for whom legal adoption proceedings have been initiated), under custody pursuant to a court order, or under legal guardianship,* ***until the age of twenty-six (26) or for two years after the end of the calendar year in which such person last qualified as a dependent under 26 U.S.C 106, whichever occurs first;*** *or*

5. *A child who depends upon the employee, retiree or surviving spouse for support, lives within the NHP Service Area with such an employee, retiree or surviving*

spouse, and where there is evidence of a regular parent-child relationship satisfactory to the Group Insurance Commission ***until the age of twenty-six (26) or for two years after the end of the calendar year in which such person last qualified as a dependent under 26 U.S.C 106, whichever occurs first;*** *or*

6. *A child under the age of nineteen (19) years who is the surviving Dependent of an employee or retiree or surviving spouse* ***until the age of twenty-six (26) or for two years after the end of the calendar year in which such person last qualified as a dependent under 26 U.S.C 106, whichever occurs first;*** *or until he/she is eligible for other group Health Coverage, whichever occurs first; or*

7. *A child who, upon becoming twenty-six (26) years of age, is mentally or physically incapable of earning his/her own living (self-support), as determined by the Group Insurance Commission; or*

8. *An unmarried full-time student, twenty-six (26) years and older and for whom an additional premium charge is being paid; or*

9. *A newborn child of the Subscriber's Dependent son or daughter until the earlier to occur of (1) the date the parent of such child ceases to be an eligible Dependent of the covered employee or retiree or surviving spouse or (2) the date the child ceases to be a Dependent.*

Handicapped Dependents

A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the subscriber's plan will continue to be covered after he or she would otherwise lose dependent eligibility, so long as the child continues to be mentally or physically incapable of earning his or her own living. Dependents who, at age 19, are mentally or physically incapable of earning their own living may be eligible for handicapped dependent coverage. Please contact GIC and submit GIC's Handicapped Dependent Coverage application to apply for this coverage. Your dependent's application will be reviewed and if approved, the child's coverage will be continued on either a temporary or permanent basis.

Residence

To be eligible for NHP Membership, all Subscribers and their Dependents, with the exception of student Dependents, must reside at least 9 months of each year within the NHP Service Area (also known as the "Service Area"). NHP's Service Area covers most all Massachusetts counties, cities and town (see page 16).

However, because Service Areas change periodically, it is important that you check the availability of Provider in your area to verify they are part of the NHP Provider Network.

Effective Date and Enrollment Requirements

Persons who meet the eligibility requirements of the section titled "Eligibility" and subsections titled "Subscriber", "Dependent" and or "Residence" may enroll in NHP by submitting a completed Enrollment application to their GIC Coordinator and to NHP. An applicant is enrolled only upon acceptance of the Enrollment application by the GIC and NHP. At the time of Enrollment, each Member enrolled will be required to choose the NHP Primary Care Provider to whom he/she must go for primary care. Members of a family may choose different NHP Primary Care Providers for their individual care. Each Member chooses or is assigned to a Primary Care Provider (PCP) who provides or arranges for a Member's Covered Services.

Effective Date

Please see your GIC Coordinator for information on Enrollment and Effective Dates of coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), individuals may enroll in NHP at any time if:

1. *The employee's spouse or eligible Dependent has lost other insurance.*
2. *The employee marries.*
3. *The employee has a newborn or adopts a child.*
4. *The employer contributions toward the Dependent's Coverage are terminated.*

For items #1, 2, and 4, the Effective Date will be determined by the GIC. For item #3, the Effective Date must be the date of birth in the case of a newborn Dependent or in the case of an adoptive Dependent, the Effective Date must be the date of adoption or placement for adoption.

New Dependents

1. *New Dependents of a Subscriber with Family Coverage may be added as of the date of marriage, birth, adoption or other qualifying event if notice of the addition is sent to GIC and NHP within 30 days of the date the dependency is established, and the applicable premium has been received by GIC. If notification of the qualifying event is not received within 30 days, then the Effective Date is determined by the GIC.*
2. *New Dependents of a Subscriber with Individual Coverage, including newborn children, will be covered as Dependents only if the Subscriber obtains Family Coverage within 30 days of the date dependency is established and applies for and has been approved for Family Coverage. You can apply for Family Coverage with the GIC Coordinator at your agency. A Subscriber shall not be permitted to change from individual to Family Coverage, or from Family Coverage to Individual Coverage, more than once within each contract year.*

Existing Family Members

Existing eligible family Members may be added as Dependents when the Subscriber changes from Individual to Family Coverage.

Adoptive Dependents

A legally adopted child under the age of nineteen (19) is eligible for Enrollment from the date the child is physically placed in the custody of the home of the Subscriber or Dependent for the purpose of adoption; or if the child resided previously in the Subscriber's or Dependent's home as a foster child, from the date of the filing of the petition to adopt.

Enrollment While Hospitalized

If a covered person is hospitalized on the date that his/her coverage takes effect, coverage shall be provided by the Plan as of that date; however, the covered person, if physically capable, must notify the Plan within 48 hours of the date his/her Coverage takes effect, and, following notification, must comply with the Plan's instructions with respect to further care.

Student Dependent Coverage

When your Dependent child goes to school away from home, he or she is still covered by NHP. NHP Coverage works one of two ways for student Dependents, depending upon where they go to school.

Students Inside the NHP Service (Enrollment) Area

If your Dependent child goes to school inside the NHP Service Area (see page 16), then he or she can choose an NHP Primary Care Provider near school. This Provider manages your child's care just as your Primary Care Provider does for you.

The NHP Service Area is where Members must live to be eligible for Enrollment. Please see the following information about student Dependents who live outside of the NHP Service Area. The NHP Service Area includes all the places where NHP Providers are available to care for Members. NHP may revise the NHP Service Area from time to time. Please call the Customer Care Center at 1-800-462-5449 (TTY 1-800-655-1761) if you have further questions regarding the Service Area.

Students Outside the NHP Service (Enrollment) Area

If your child goes to school outside the NHP Service Area, NHP provides special Coverage. This is because there are no nearby NHP Primary Care Providers who can manage your child's care while he or she is going to school. This special Coverage allows benefits for care that could not have been foreseen before your child left the Service Area. All the rules and limits on Coverage listed in the Benefit Handbook apply to these benefits, except that your Dependent child does not need to get care through his or her Primary Care Provider. Please note that your Dependent child is entitled to all the benefits in this Agreement when he or she returns to the Service Area and receives care from NHP Providers. All benefit limits specified on the Evidence of Coverage shall apply to care outside of the NHP Service Area for student Dependents.

Eligibility for Out-of-Area Student Coverage

Coverage for students living outside the NHP Service Area is available only to a Dependent who is:

- *A child of a Subscriber or Subscriber's spouse who meets the definition of Dependent according to the Agreement between NHP and the GIC; Enrolled on a full-time basis at an accredited educational institution located outside the NHP Service Area, and; Registered in advance with NHP as a student attending school outside the NHP Service Area.*

NHP may require reasonable evidence that a Member meets the above requirements.

Benefits for Out-of-Area Student Coverage

For student Dependents who attend school outside the Service Area, NHP covers the following services when Medically Necessary and related to a specific illness or condition. Copayments will be applied as listed on the GIC Summary of Benefits.

Outpatient Services: NHP covers all Outpatient Services listed in this Benefit Handbook and the Summary of Benefits except the following:

- *Routine examinations and preventive care, including immunizations; Home health care, including maternity programs and house calls; Reconstructive surgery; Elective outpatient surgical procedures; Second opinions.*

Inpatient Services: NHP covers all Inpatient Services listed in this Benefit Handbook, except for elective procedures. Elective procedures are services that can be delayed until your child's return to the Service Area without permanent damage to his or her health. Call your Primary Care Provider and NHP within 48 hours of Hospitalization.

Status Changes

It is your responsibility to notify Neighborhood Health Plan about any changes that may affect your or your dependents' eligibility for coverage, such as:

- *An addition to the family*
- *The marriage of a Dependent*
- *An address change*
- *Death of a Member*
- *Change in marital status*

Please note that Neighborhood Health Plan must have your current address and telephone number on file so that we can contact you when necessary and to correctly process Claims for care outside the NHP Service Area. You must notify the Group Insurance Commission (GIC) and NHP of any changes in your status. Be sure to call the NHP Customer Care Center at 1-800-462-5449 (TTY 1-800-655-1761). Also, please inform your GIC Coordinator at your work site.

Disenrollment

Voluntary Termination by the Subscriber

You may end your NHP membership with the GIC's approval. NHP must receive notification from the GIC within ninety (90) days of the date you want your Membership to end.

Termination for Loss of Eligibility

NHP may end or refuse to renew a Member's Coverage for failing to meet any of the specified eligibility requirements. The NHP Subscriber will be notified in writing if Coverage ends for loss of eligibility. You may be eligible for continued coverage under federal or state law, if your membership is terminated. See "Continuation of Employer Group Coverage" for more information.

Please note that NHP may not have current information concerning membership status. The GIC may notify NHP of Enrollment changes retroactively. As a result, the information we have may not be current—only the GIC can confirm membership status.

Membership Termination for Cause

Neighborhood Health Plan may terminate or refuse to renew a Member's coverage for the following reasons:

- *The failure by the GIC to make payments required under the contract.*
- *Providing false or misleading information on an application for Membership or misrepresentation or fraud on the part of the Member.*
- *The commission of acts of physical or verbal abuse by a Member that pose a threat to Providers, staff at Providers' offices or other Members and that are unrelated to the Member's physical or mental condition.*
- *Relocation of the Member outside NHP's Service Area.*
- *Non-renewal or cancellation of the GIC contract through which the Member receives Coverage.*

Notice of Termination of Membership for providing false information shall be effective immediately upon notice to a Member. Notice of termination of Membership for other causes will be effective fifteen (15) days after notice. Premium paid for periods after the Effective Date of termination will be refunded.

Continuation of Employer Group Coverage Required by Law

Contact the GIC for more information if membership ends due to:

- *Loss of dependency due to age;*
- *Termination from employment or reduction of work hours;*

If you lose Group coverage you may be eligible for continuation of group Coverage under

the Federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Divorce or legal separation

In the event of divorce or legal separation, a spouse may be eligible to keep coverage under the employee's membership, as determined by the GIC. This is the case only until the employee is no longer required by law to provide health insurance for the former spouse. While the former spouse continues coverage under the employee's membership, there is no additional premium. After remarriage of the employee, under state and federal law, the former spouse may be eligible to continue coverage under an individual membership for additional premium, as determined by the GIC.

Group Health Continuation Coverage Under COBRA

It is important that you read this notice if your current GIC coverage is ending due either to (1) end of employment, (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This notice contains important information about your right to temporarily continue your health care coverage in the Group Insurance Commission's (GIC's) health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete a GIC COBRA Election Form and return it to the GIC by no later than 60 days after your group coverage ends by mailing it to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114 or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617/727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at www.dol.gov/ebsa.

WHAT IS COBRA COVERAGE?

COBRA is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

WHO IS ELIGIBLE FOR COBRA COVERAGE?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events.

1. *If you are an employee of the Commonwealth of Massachusetts covered by the GIC's Health benefits program, you have the right to choose COBRA coverage if you lose your group health coverage because your hours of employment are reduced; or your employment ends for reasons other than gross misconduct.*

2. *If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):*

- *Your spouse dies;*
- *Your spouse's employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours or employment are reduced; or*
- *You and your spouse divorce or legally separate.*

3. *If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):*

- *The employee-parent dies;*
- *The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;*
- *The parents divorce or legally separate; or*
- *The dependent ceases to be a dependent child (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).*

HOW LONG DOES COBRA COVERAGE LAST?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event—the insured's death or divorce—occurs during the 18 months of COBRA coverage. You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- *The COBRA cost is not paid in full when due (see section on paying for COBRA);*
- *You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;*
- *You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);*
- *The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or*
- *Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).*

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST?

Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but you are responsible for paying for the coverage even if you do not receive a monthly statement. Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The GIC has no involvement in conversion programs, and you pay premium to the health plan for the conversion coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

You must inform the GIC of any address changes to preserve your COBRA rights;

You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.

You must make the first payment for COBRA coverage within 45 days after you elect COBRA. If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.

You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.

You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:

- *The employee's job terminates or his/her hours are reduced;*
- *The employee or former employee dies;*
- *The employee divorces or legally separates;*
- *The employee or employee's former spouse remarries;*
- *A covered child ceases to be a dependent;*
- *The Social Security Administration determines that the employee or a covered family member is disabled; or*
- *The Social Security Administration determines that the employee or a covered family member is no longer disabled.*

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

Non-Group Coverage

When your NHP coverage ends, you may be eligible to enroll in a non-group plan offered by NHP. The benefits and premium charges for these non-group plans may differ from your coverage provided under this contract. For more information about non-group coverage call NHP Customer Care at 1-800-462-5449 (TTY 1-800-655-1761).

Members Eligible for Medicare

NHP does not offer health plans for individuals eligible for Medicare. You may contact the GIC for information about health plans for people eligible for Medicare.

Section 3.
Your NHP Providers

NHP GIC Provider Directory

At time of enrollment, NHP makes available a Provider Directory to new Members. NHP also provides directories to prospective or current Members upon request. To request a copy of the Provider Directory, call the Customer Care Center at 1-800-462-5449, TTY 1-800-655-1761, or visit our website at www.nhp.org for the most up-to-date listing of Providers. The NHP GIC Provider Directory lists Primary Care Sites, Primary Care Providers, Hospitals, NHP-affiliated Specialists, and Mental Health and Substance Abuse Care Providers in the NHP Network.

Your Primary Care Provider

All Members must choose a Primary Care Provider upon Enrollment in NHP. Your Primary Care Provider provides or arranges all of your health care. To choose a Primary Care Provider or Primary Care Site, call the NHP Customer Care Center at 800-462-5449 or TTY 800-655-1761. You should choose a Primary Care Site close to your home or workplace. If you do not choose a Primary Care Provider within fifteen (15) days of your Enrollment date, NHP will assign you a Primary Care Provider. NHP will also assign a Provider to you if your first choice of Primary Care Provider is not available. To change your Primary Care Provider contact NHP's Customer Care Center.

NHP is aware that there are some physicians who charge an annual fee to patients as a condition to be part of the physician's panel of patients and to receive special customer service from the provider (e.g. access to the provider's cellular telephone, more personalized service). Members who use physicians who provide additional customer service for a fee (concierge service) should be advised that those concierge services are not part of NHP's health plan coverage. Members are asked to notify NHP if their provider approaches them to offer/deliver such services for additional fees. Neighborhood Health Plan does not support this practice.

Primary Care Provider Tiers

When choosing a Primary Care Provider (PCP), please note that NHP has implemented group practice (site) level Tiering for Primary Care Providers (PCP's) for GIC members in the NHP Care HMO Plan. NHP based its PCP Tiering on quality and cost-effectiveness standards developed by the GIC for its Clinical Performance Improvement Initiative (CPII). Each contracted PCP group practice (site) has been given an overall quality and cost-effectiveness score based on the CPII data that places it into one of three levels:

*** Tier 1 (excellent);
** Tier 2 (good); or
* Tier 3 (standard).

Sites with the highest combined quality and cost-effectiveness scores have been assigned to Tier 1. Sites with scores that fall within the middle range are assigned to Tier 2, and sites with standard scores are assigned to Tier 3. Your choice of PCP will determine your office visit Copayment based on the site at which that PCP practices. The Tier 1 Copayment is $10 per office visit, the Tier 2 Copayment is $20 per office visit, and the Tier 3 Copayment is $25 per office visit. The office visit copay for PCP sites with insufficient data for comparison is $20.

Please note that PCPs are tiered at the site level and not the individual level. Should you change your PCP to a PCP practicing at a site that is in a different Tier or should your PCP move to a site in a different Tier, you will be subject to the new site's applicable Copayment. Please refer to the NHP GIC Provider Directory to verify the site address and Tier of your PCP.

To obtain the most up-to-date information on your provider's Tier, please refer to the online

version of your provider directory located at www.nhp.org and click on the provider directory link. You may also contact our Customer Care Center at 1-800-462-5449 (TTY 1-800-655-1761) if you would like a copy of the NHP Primary Care Directory, which contains important information about Primary Care Sites, Primary Care Providers, and Hospitals.

Changing Your Primary Care Provider or Primary Care Site

Your Primary Care Provider can provide better care when he or she knows you and your medical history. For this reason, NHP encourages you to have an ongoing relationship with your Primary Care Provider. If you need to change your Primary Care Provider, you may do so at any time, for any reason. To change your Primary Care Provider, call the Customer Care Center at 1-800-462-5449 (TTY 1-800-655-1761). A Customer Care Center representative will assist you with your selection and process the change. If you choose a new Primary Care Provider at the same Primary Care Site, the change will be effective the next business day. If you choose a new Primary Care Provider at a different Primary Care Site, the change will be effective as of the first day of the next month. Should you change your Primary Care Provider to a Primary Care Provider practicing at a site that is in a different Tier or should your Primary Care Provider move to a practice site in a different Tier, you will be subject to the new site's applicable Copayment.

Please refer to the NHP GIC Provider Directory to verify what Tier your Primary Care Provider is assigned to. To obtain the most up-to-date information on your provider's Tier, please refer to the online version of your provider directory located at www.nhp.org and click on the provider directory link. You may also contact our Customer Care Center at 1-800-462-5449 or email, PRWEB@nhp.org.

For the most up-to-date information about any NHP provider in our network, visit our Web site at www.nhp.org.

Why It's Best to Call Your Primary Care Site

Calling first can save you a needless trip to the Emergency room—and hours of waiting and worrying. You will get the quickest and best advice from people who know you well. For example, your Primary Care Site's doctor or nurse on call may tell you how to treat your problem at home. If the doctor or nurse thinks that you need to go to the Emergency room, he or she will tell you exactly where to go. The doctor or nurse can also let the Emergency room know you are coming.

Get to Know Your Primary Care Provider

It is a good idea to meet your new Primary Care Provider before you need care. To make an appointment, call your Primary Care Site. Your site's telephone number is printed on the front of your NHP Member ID Card. When you call, be sure to say that you are an NHP Member. You should request your old Primary Care Provider to send your health records to your new Primary Care Site before this visit.

When you go to your appointment, show your NHP Member ID card. You and your Primary Care Provider can use this appointment to get to know each other. After this first appointment, call your Primary Care Site whenever you need health care. In an Emergency, seek immediate care at the nearest facility.

Behavioral Health (Mental Health and Substance Abuse) Providers

NHP Members have access to a full range of Behavioral Health (mental health and substance abuse) services. Beacon Health Strategies is the

organization that manages NHP's Behavioral Health program. Some examples of Behavioral Health (mental health and substance abuse) Services are individual, group and family counseling and methadone treatment. For a complete listing of Behavioral Health Services, refer to Section 8 of this Handbook. If you need Behavioral Health Services, you may choose any Provider in NHP's Behavioral Health Network. You can make the appointment on your own or call Beacon Health Strategies clinical department at 800-414-2820 (TTY 781-994-7660) to help you find a Provider. You may also ask for assistance from your Primary Care Provider. For information about NHP's Behavioral Health Network Providers, refer to the Behavioral Health section of your NHP Provider Directory in your Member kit, call Beacon Health Strategies clinical department at 800-414-2820 (TTY 781-994-7660) or call NHP's Customer Care Center at 800-462-5449 (TTY 800-655-1761).

Specialty Care

At times, your Primary Care Provider may suggest that you see a Specialist. Specialists are doctors who focus on one area of medicine. Examples of Specialists are cardiologists, dermatologists and allergists. Neighborhood Health Plan does not require referrals for you to receive care from any NHP network specialist, however, your PCP is the best person to help you coordinate your healthcare. When you have an established connection with your PCP, he or she can help you address all aspects of your health care and assist you in coordinating all the services you need. Before making your appointment with an In-Plan specialist, your PCP can discuss the situation, consider options and help decide where you can get the services you need. Some specialty care providers will require a clinical summary from your doctor before they will see you. For example, a neurologist may want to obtain your PCP's opinion, or a Physical Therapist may be required to obtain a PCP treatment order. They can communicate directly with each other and are not required to obtain a referral ID number from NHP for these services. It is your responsibility to make sure that the specialist you wish to see participates with NHP and is available in NHP's network. When you use in plan providers, you know that they have been credentialed by NHP and that they will work with our medical staff to help ensure you get the care you need. You may search our provider directory or call the Customer Care Center at 1-800-462-5449(TTY 1-800-655-1761).

Out-of-Network Specialty Care

You may visit an out-of-network specialist only if Neighborhood Health Plan approves it in advance. Services provided by Out-of-Plan Specialists require prior authorization. If there are in-plan providers who offer the service, NHP will usually deny the request to cover out-of-plan services. Before you schedule an appointment or seek medical care from an out-of-plan specialist, ask your Primary Care Physician or treating doctor to send an authorization request to NHP. After reviewing the request, we will notify you and your doctor of our decision in writing. If you do not receive written approval from NHP for out-of-plan specialty care, the plan will not cover the services. If you do receive authorization for out-of-plan specialty care, copayments, if any will remain the same. NHP will arrange payment to the Out-of-Network Provider. All NHP Members have access to our comprehensive network of Specialists. If you need specialty care, your Primary Care Provider is able to coordinate your care with a Specialist. Referrals are not required for NHP in-plan specialists, Behavioral Health (mental health and substance abuse) Services, Family Planning or Emergencies.

Specialty Care Provider Tiers

When in need of specialty care, please note that as of July 1, 2008, NHP has implemented Specialty Provider level Tiering for the following specialties: Cardiology, Endocrinology, OB/GYN, and Gastroenterology services. NHP based this Specialty Provider Tiering on quality and cost-effectiveness standards developed by the GIC for its Clinical Performance Improvement Initiative (CPII). Each contracted Cardiology, Endocrinology, OB/GYN, and Gastroenterology specialist has been given a quality and cost-effectiveness score based on the CPII data that places it into one of three levels:

*** Tier 1 (excellent);
** Tier 2 (good); or
* Tier 3 (standard).

Specialists with the highest combined quality and cost-effectiveness scores have been assigned to Tier 1. Specialists with scores that fall within the middle range are assigned to Tier 2. Specialists with standard scores are assigned to Tier 3. Your choice of Cardiology, Endocrinology, OB/GYN, and Gastroenterology Specialist will determine your office visit Copayment based on his/her Tier. The Tier 1 Copayment is $15, Tier 2 Copayment is $25 and the Tier 3 Copayment is $35 per office visit. The office visit copayment for tiered providers who have insufficient data for comparison or for specialty providers who are not being tiered is $25. Your Copayment for outpatient Mental Health or Substance Abuse providers is $10. Please refer to the NHP GIC Provider Directory to verify the Tier of your Specialty Provider.

If you are seeing a covering specialist in one of the four specialty categories, Cardiology, Endocrinology, OB/GYN, and Gastroenterology and the covering Specialist is assigned to the same tier as the specialist you normally see, your Copayment will be the same. However, if the covering Specialist in one of these four specialty categories is assigned to a different tier, your Copayment may be different. You should refer to the Provider Directory to determine the tier of any Specialist you choose to see.

To obtain the most up-to-date information on your provider's Tier, please refer to the online version of your provider directory located at www.nhp.org and click on the provider directory link. You may also contact our Customer Care Center at 1-800-462-5449 (TTY 1-800-655-1761).

Please see your Benefit Summary for specific information about your benefits. If you have questions about benefits or specialty care, please call the NHP Customer Care Center at 1-800-462-5449 (TTY 1-800-655-1761).

Relationship of NHP to NHP Providers

NHP Providers are independent contractors. NHP's relationships with its Providers are governed by separate contracts. Providers may not change the Evidence of Coverage or create or imply any obligation for NHP. NHP is not liable for statements about this agreement made by Providers, their employees, or agents. NHP cannot guarantee the availability of individual Providers or Provider groups. NHP may change arrangements with Providers, including the addition or removal of Providers. Please note that all Providers listed in any of the NHP Provider Directories were available to NHP members at the time the directories were printed. For the most up-to-date information on NHP Providers, refer to our online Provider directory located at www.NHP.org.

Continuity of Medical Care

In order to ensure continuity of care, there are some circumstances when NHP will provide coverage for health services from a Provider who is not participating in NHP's Network.

- *If you are enrolling in NHP as a new Member and your employer only offered you a*

choice of Carriers in which your existing PCP or an actively treating Provider was not a participating provider, NHP will provide coverage for up to thirty calendar (30) days from the Effective Date of coverage. With respect to a Member in her second or third trimester of pregnancy, this provision applies to services rendered through the first postpartum visit by the Provider caring for her pregnancy. With respect to a Member with a terminal illness, this provision applies to services rendered until death.

- *If your Provider has been disenrolled from NHP's network, for reasons unrelated to quality of care or fraud, NHP will provide coverage for up to 30 calendar days if the Provider is your Primary Care Provider or up to 90 calendar days if the Provider, including a PCP, is providing you with active treatment for a chronic or acute medical condition or until that active treatment is completed, whichever comes first. For any Member who is in her second or third trimester this coverage will continue through the first postpartum visit. For any Member who is terminally ill, this coverage will continue through the Member's death.*

To continue care in the above situation, the Provider must adhere to the quality assurance standards of NHP and provide NHP with necessary medical information related to the care provided. In addition, the Provider must adhere to NHP's policies and procedures, including procedures regarding prior authorizations and providing services pursuant to a treatment plan, if any, approved by NHP. In the case of disenrolled Providers, they must also agree to accept reimbursement from NHP at the rates applicable prior to notice of disenrollment as payment in full, and not to impose cost sharing with respect to the Insured in an amount that would exceed the cost sharing that could have been imposed if the Provider had not been disenrolled. Failure of a Provider to agree to these conditions may result in a denial of coverage for the provided service. If you have any questions regarding this matter please call the Customer Care Center at 800-462-5449, TTY 800-655-1761.

Section 4.
Accessing Care

Emergency Care

In an Emergency, go to the nearest Emergency facility, call 911, or call your local Emergency number. You are always covered for care in an Emergency.

An Emergency is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment of body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, placing the insured or her unborn child's physical or mental health in serious jeopardy. With respect to a pregnant woman who is having contractions, an emergency also includes having an inadequate time to effect a safe transfer to another hospital before delivery or a threat to the safety of the member or her unborn child in the event of transfer to another hospital before delivery.

You or your representative (such as another member of your family) must call your Primary Care Site within 48 hours of any Emergency care. Notification by the attending Emergency physician to NHP or to your Primary Care Provider within 48 hours of receiving Emergency services will also satisfy this requirement. Your Primary Care Provider will arrange for any follow-up care you may need. You will not be denied coverage for medical and transportation expenses incurred as a result of any such Emergency.

After you have been stabilized for discharge or transfer, NHP may require a Hospital Emergency department to contact a physician on-call designated by NHP or its designee for authorization of post-stabilization services to be provided. The Hospital Emergency department shall take all reasonable steps to initiate contact with NHP or its designee within 30 minutes of stabilization. Such authorization shall be deemed granted if NHP or its designee has not responded to said call within 30 minutes. In the event the attending physician and on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of attending physician will prevail and treatment shall be considered appropriate treatment for an Emergency medical condition, provided, that such treatment is consistent with general accepted principles of professional medical practice and is a Covered Health Care Service under the policy or contract with NHP.

Urgent Care

Urgent Care is care for a health problem that needs medical attention right away but you do not think it is an Emergency. For an Urgent Care visit, call your Primary Care Provider or Primary Care Site. You can contact your Primary Care Site twenty-four (24) hours a day, seven (7) days a week. Urgent Care does not include care that is elective, Emergency, preventive or health maintenance. Examples of conditions requiring Urgent Care include but are not limited to fever, sore throat, earache, and acute pain.

Non-Emergency Hospital Care

If you need hospital care and it's not an Emergency, your Primary Care Provider will make the arrangements for your hospital stay. You must go to the hospital specified by your Primary Care Provider in order for NHP to cover your hospital care. NHP will cover hospital care only if your Primary Care Provider or Primary Care Site arranges such care. The only exception is for Emergency care.

If you change your Primary Care Provider, your new Primary Care Provider must arrange for any further hospital care.

Behavioral Health Hospital Care

If you feel you need Inpatient hospital care for Behavioral Health needs, call 911 or your local Emergency phone number, or go to the nearest Emergency room right away. At the Emergency room you will be screened and evaluated for admission. For a listing of Emergency Rooms in all areas of the state, refer to your NHP Provider Directory. You can also call Beacon Health Strategies' clinical department at 1-800-414-2820 (TTY 1-781-994-7660) or your Primary Care Provider.

After Hours Care

No matter when you are sick—day or night, any day of the year—call your Primary Care Site. All NHP Primary Care Sites have a doctor or nurse on call 24 hours a day, 7 days a week. The doctor or nurse on call is there to help with urgent health problems. When you call your Primary Care Site after hours, the site's answering service will answer your call. The service will take your name and telephone number and contact the doctor or nurse on call. That doctor or nurse will call you back to talk about your problem and help you decide what to do next.

For Behavioral Health after hours care, call your Behavioral Health Provider first. You may also call Beacon Health Strategies' clinical department 24 hours a day, seven days a week at 1-800-414-2820 (TTY 1-781-994-7660).

If you think your health problem is an Emergency and needs immediate attention, call 911 or your local Emergency number at once or go to the nearest Emergency room.

Care When Outside the NHP Service Area

When Members are traveling or temporarily residing outside the NHP Service Area, including students attending school outside the NHP Service Area, NHP will cover only Emergency and Urgent Care services. To ensure coverage, be sure to take care of your routine health care needs before traveling outside of the NHP Service Area. If you need Emergency Care or Urgent Care while you are temporarily outside the NHP Service Area, go to the nearest doctor or Emergency room. You do not have to call your Primary Care Provider before seeking Emergency or Urgent Care while outside the NHP Service Area. You or a family member should call your Primary Care Site within 48 hours of receiving out-of-area care and before receiving any follow-up services related to your urgent or emergent need. Except for Emergency or Urgent Care, failure to obtain prior authorization for services outside the NHP Service Area may result in Member liability for payment.

NHP will not cover:

- *Tests or treatment requested by your Primary Care Provider before you left the Service Area*
- *Routine Care or follow-up care that can wait until your return to the Service Area, such as physical exams, flu shots, stitch removal, mental health counseling*
- *Care that could have been foreseen prior to leaving the Service Area such as elective surgery*
- *Care for childbirth or problems with pregnancy beyond the 37th week of pregnancy, or after being told that you were at risk for early delivery*

A Provider may ask you to pay for care received outside of NHP's Service Area at the time of service. If you pay for Emergency Care or Urgent Care you received while outside of NHP's Service Area, you may submit a Claim to NHP for reimbursement. See the section on "If You Receive a Bill in the Mail" on page 66 for further

information and instructions on how to submit a Claim. You may also call the Customer Care Center for assistance with any bills that you may receive from a health care Provider.

Family Planning Services

Family Planning Services include birth control methods as well as exams, counseling, pregnancy testing, and some lab tests. You may call any NHP contracted Family Planning clinic for an appointment. You may also see your Primary Care Provider for Family Planning Services. Call the NHP Customer Care Center if you need help finding a Provider for Family Planning Services.

Maternity Care

NHP covers many services to help you have a healthy pregnancy and a healthy baby. If you think you might be pregnant, call your Primary Care Site. Your site will schedule an appointment for a pregnancy test. If you are pregnant, your Primary Care Site will arrange your maternity care with an obstetrician or nurse midwife. You will be scheduled for regular checkups during your pregnancy. It is important to keep these appointments even if you feel well. During these appointments, your obstetrician or nurse midwife will check your baby's progress. He or she will tell you how to take good care of yourself and your baby during your pregnancy. He or she will also take care of you when you have your baby. NHP also has a special program for pregnant Members called For You Two. For more information about this program, see page 63. If you become pregnant, you may be eligible for Medicaid (MassHealth). For more information, call the NHP Customer Care Center at 800-462-5449 or TTY 800-655-1761. If you have any questions about how to enroll your baby in NHP, call the NHP Customer Care Center.

Section 5.
Authorizations

Authorizations

An Authorization is a special approval by NHP for payment of certain services. Not all services require Authorization. But, if a service does require Authorization, Authorizations must occur before you receive the service in order for the service to be covered. Your Primary Care Provider or the Specialist treating you will request an Authorization if it is necessary. For health plan benefits, the request is submitted to NHP. Examples of services requiring Authorization from NHP are physical therapy, speech therapy, surgical procedures and elective admissions, Inpatient psychiatric care, etc. NHP gives Authorizations as soon as possible.

For an initial Authorization regarding a proposed admission, procedure or service, Authorization decisions are made within two (2) business days of obtaining all necessary information and Providers are informed of the decision within 24 hours. The Provider and the Member receive written notification of the decision within one (1) business day of the verbal notification for Adverse Determinations, and within two (2) business days for approvals.

Urgently needed services provided during non-business hours require notification by the next business day.

Concurrent Authorization decisions are made within one (1) business day of obtaining all necessary information. In the case of a determination to approve an extended stay or additional services, Providers are verbally informed of the decision within one (1) business day. Written or electronic confirmation is sent to the Provider and Member within one (1) business day thereafter. Written or electronic notification includes the number of extended days or the next review date, updated total number of days of service approved and the date of admission or initiation of services. In the case of an Adverse Determination, verbal notification is sent to the Provider within 24 hours and written or electronic notification is sent to the Provider and Member within one (1) business day thereafter.

Once NHP reviews the request for service(s), we will inform your Provider of our decision. If we authorize the service(s), we will send you and your Provider an Authorization letter. When you get the letter, you can call your Provider to make an appointment. The Authorization letter will state the service(s) the plan has approved for coverage. Make sure you have this Authorization letter before any service(s) requiring Authorization are provided to you. If your Provider feels that you need a service(s) beyond those authorized, he or she will ask for Authorization directly from the plan.

If we approve the request for additional service(s), we will send both you and your Provider an additional Authorization letter.

If we do not authorize any of the service(s) requested, authorize only some of the service(s) requested, or do not authorize the full amount, duration or scope of service(s) requested, we will send you and your Provider a denial letter. NHP will not pay for any services that were not authorized. NHP will also send you and your Provider a notice if we decide to reduce, suspend, or terminate previously authorized service(s). If you disagree with any of these decisions, you can file a Grievance. For complete details on filing a Grievance, please refer to Section 14 of this Handbook or contact NHP's Customer Care Center for more information.

It is your responsibility to make sure that you have written Authorization for coverage prior to receiving services that require authorization. You may confirm the need for Authorization with your NHP providers or by contacting NHP's Customer Care Center.

Section 6.
NHP's Pharmacy Benefit

Neighborhood Health Plan pharmacy benefit is committed to providing a high quality and cost effective pharmacy benefit for our members. Your coverage includes a variety of prescription drug programs that are designed to make paying for your medications more affordable and keep your premiums affordable. The NHP pharmacy benefit places all covered drugs into one of three levels or tiers. Copayments apply to each tier, which are listed in your Benefit Summary and on your Member Identification card. Depending on the plan, a prescription drug Deductible or coinsurance amount may also apply. All Copayments, prescription drug deductibles and coinsurance amounts, if applicable, are outlined in your Benefit Summary. Additional information about your financial obligations is included on page 67 of this Member Handbook.

Tier Placement

Neighborhood Health Plan's prescription drug benefit places all covered drugs into one of three levels, or tiers, including:

- ***Tier 1: Lowest Copayment Level***
  This tier includes most generic medication and some inexpensive brand name medication.
- ***Tier 2: Middle Copayment Level***
  This tier includes some high cost generic medication and preferred brand name medication that are considered safer and more cost effective than Tier 3 medications.
- ***Tier 3: Highest Copayment Level***
  This tier includes non-preferred brand name medications which are considered less cost-effective than tier 2 medications.

Each tier includes a different Copayment amount. Copayments are fixed dollar amounts that are paid to the pharmacy at the time of purchase. In most cases, the Copayment amount represents a fraction of the total cost for a prescription.

Each Copayment covers up to a 30 day supply of medication. When prescriptions are purchased through a network pharmacy, you pay the lower of the Copayment or the pharmacy's discounted retail price. If you are traveling outside the NHP service area and purchase your medications through a non-network pharmacy, you pay the lower of the Copayment or the pharmacy's retail price. Some plans also provide coverage with a prescription drug Deductible. Your Benefit Summary indicates if you have any Deductible amounts. Once the Deductible is satisfied, then the applicable Copayment or coinsurance amount applies. Not all plans have a prescription drug Deductible. If a prescription Deductible applies to your coverage, the Deductible is paid to the pharmacy at the time of purchase. When prescriptions are purchased through a network pharmacy, the cost of your medication is based on the lower of the pharmacy's retail price or discounted retail price. If the discounted retail price for a prescription ever exceeds the balance of your remaining Deductible for the calendar year, you are required to pay the balance of the Deductible and applicable Copayment or coinsurance amount.

However, you are not obligated to pay any combination of Copayments or Deductible amounts that exceed the lower of the pharmacy's retail prices or discounted retail price for the drug.

Some plans also provide coverage with coinsurance. If your coverage requires payment of coinsurance, the applicable coinsurance percentages are listed in your Benefit Summary.

When coinsurance applies, members pay a percentage payment for a drug instead of a fixed dollar amount. In addition, your

coinsurance payment must be paid to the pharmacy at the time of purchase.

NHP's Drug List includes a list of medicines covered by your plan. Doctors and pharmacists have reviewed the medications for safety, quality, effectiveness and cost. You can determine the Tier your drug is in by viewing the searchable Drug Lookup, which is available on our website at www.NHP.org.

Filling Prescriptions

Prescriptions can be filled at any pharmacy in NHP's national network, which includes 48 contiguous states, Alaska, Hawaii and Puerto Rico. A complete listing of participating pharmacies is available on our Web site at www.NHP.org.

If you fill a prescription for a covered drug while traveling outside the NHP service area, you may have to pay the retail price for the drug then submit a claim for reimbursement. Reimbursement for drugs purchased will be paid minus the Copayment, Coinsurance and any unmet Deductible (if applicable.)

Neighborhood Health Plan offers a Mail Order, Access 90 and Over-the-Counter benefits that are convenient for our members and designed to reduce your prescription drug costs.

Mail Order Program

For members who prefer the convenience of receiving their prescriptions through the mail, certain maintenance medications (such as drugs used for asthma, blood pressure, high cholesterol and arthritis) are available through our Walgreens' Prescription by Mail Service.

The Walgreens' Prescription by Mail Service provides members with a 90-day supply of prescription medicines at a reduced cost. The Copayment for a 90 days supply is reduced for both Tier 1 and Tier 2 medications. For Tier 1 and Tier 2 medications, 2 Copayments apply for a 3 month supply. To order your prescriptions through the mail, please complete the registration form included in your enrollment kit. Members only need to complete the form once and return it in the supplied envelope.

To obtain an additional form, you may contact the NHP Customer Care Center from Monday through Friday, 8:30 A.M. to 6 P.M. at 800-462-5449. Members can order refills by contacting Walgreens from 9 A.M. to 9 P.M. Monday through Friday, (9 a.m. to 2 p.m. on Saturday) at 800-345-1985 or online at www.walgreensmail.com

Access90

Access 90 provides members with a 90-day supply of certain maintenance medications when purchased through participating pharmacies. The Copayment for a 90 day supply is reduced for both Tier 1 and Tier 2 medications. For Tier 1 and Tier 2 medications, 2 Copayments apply for a 3 month supply.

Over the Counter Drug Benefit

Some over-the-counter medications (including cough, cold and allergy) are covered by your NHP pharmacy benefit with a valid prescription from your doctor, for up to a 30 day supply. Copayments may vary depending on drug prescribed. For a complete listing of the over-the-counter drugs and applicable Copayment amounts, please refer to our website at www.nhp.org. All pharmacy programs have been developed and approved by the Neighborhood Health Plan's Pharmacy and Therapeutics Committee of physicians and pharmacists. The following prescription drug programs apply to all covered members.

Quantity Limit

NHP may limit the number of units for a specific medication you may receive in a given time period to ensure safe and appropriate use. These limits are based on recommended dosing schedules, and the availability of several strengths of the medication. Quantity limits automatically apply at the time the prescriptions are purchased.

Mandatory Generic Policy

NHP's mandatory generic policy requires a generic version of a medication be tried before the brand name medication is considered for coverage. A generic drug is the same medication and works in the same way as the brand name medication. Generic medications are approved by the US Food and Drug Administration (FDA) as safe and are the equivalent of the original brand name medication. In addition, there are usually multiple manufacturers of a generic medication that may result with a lower cost compared to the branded alternative. Prior authorization is required for exception to NHP's mandatory generic medication pharmacy benefit. If you have already tried a generic equivalent, and wish to appeal the mandatory generic policy, you may contact NHP Customer Care Center from Monday through Friday, 8:30 A.M. to 6 P.M. at 800-462-5449 (TTY 800-655-1761).

Prior Authorization

Prior authorization is a process in which a clinical review is required before a specific medication may be dispensed to a covered NHP member. The review entails the application of criteria approved by NHP's Pharmacy and Therapeutics Committee of physicians and pharmacists and is designed to assure the safe, effective and appropriate use of a medication. These criteria are based on clinical studies and standards of care. The prior authorization process may entail a delay in your ability to fill the prescription until the clinical review based on information provided by your physician (or his/her designee). The clinical review process may take up to 48 hours after complete information has been received.

Step Therapy

NHP automates the prior authorization criteria for some medications. NHP member's who qualify for this program may enjoy immediate coverage without the requirement of a clinical review based on the prescriptions already filled through NHP. For additional information, you may contact NHP Customer Care Center from Monday through Friday, 8:30 A.M. to 6 P.M. at 800-462-5449 (TTY 800-655-1761).

Specialty Pharmacy Program

The NHP Specialty Pharmacy Program offers a less costly method to purchasing expensive injectable drugs and medications that are used to treat complex medical conditions. Certain medications and injectables are covered only when obtained from NHP's preferred list of Specialty Pharmacies. A complete list of prescriptions included in the Specialty Pharmacy program, along with the list of participating specialty pharmacies, are available on our website at www.NHP.org. You may also determine if your drug is included in the program through the searchable Drug Lookup, also available on our website at www.NHP.org. Your primary care physician can assist you with the purchase of the covered specialty medications. If your prescription is included in the Specialty Pharmacy Program, please contact your doctor who will help you complete and submit a new prescription referral form to the correct specialty pharmacy. You will not be able to purchase specialty drugs through our other participating network pharmacies and will only be able to purchase the drugs through a preferred specialty pharmacy. NHP Specialty Pharmacies have expertise in the delivery of the medications they provide, and offer special services not available at a traditional retail pharmacy, including:

- *All necessary medication and supplies needed for administration (at no additional charge)*
- *Convenient delivery options to your home or office with overnight or same day delivery available when medically necessary*
- *Access to nurses, pharmacists and care coordinators specializing in the treatment of your condition, who are available 24 hours a day, seven days a week, to provide support and educational information about your medications*
- *Compliance monitoring, adherence counseling and clinical follow-up*
- *Educational resources regarding medication use, side effects, and injection administration*

For additional assistance, or if you have any questions about NHP's Specialty Pharmacy Program, please call Customer Care Center from Monday through Friday, 8:30 a.m. to 6 p.m. at (800) 462-5449.

Limitations

There are a number of prescription drugs that are either not covered or for which coverage is limited. NHP only covers drugs that are Medically Necessary for preventive care or for treating illness, injury, or pregnancy.

Exceptions

You or your provider may request an exception for coverage of any drug that is excluded or limited. Exceptions may only be granted for clinical reasons. For additional information, please contact Customer Care Center from Monday through Friday, 8:30 A.M. to 6 P.M. at 800-462-5449.

NHP has a number of on-line tools to help our members understand their prescription drug benefits. Please refer to our Web site at www.NHP.org for a listing of covered drugs. You may also learn about your medication's tier placement, if any benefit restrictions or limitations apply, and get detailed information about your medications. By clicking on the highlighted medication you can also obtain detailed information about the medication through the Healthwise Knowledgebase.

Exclusions

NHP's prescription drug benefit features an open Preferred Drug List, in which the following drugs or services are excluded:

- *Dietary supplements*[1]
- *Therapeutic devices or appliances (except where noted)* [1]
- *Biologicals, immunization agents or vaccines*[2]
- *Blood or blood plasma*[2]
- *Medications which are to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, nursing home, or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals* [2]
- *Charges for the administration or injection of any drug* [2]
- *If an FDA approved generic drug is available, the brand name equivalent is not covered*
- *Anabolic steroids*
- *Progesterone supplements*
- *Fluoride supplements/vitamins over age 13.*
- *Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only*
- *Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual*

- *Medications for which the cost is recoverable under Worker's Compensation or Occupational Disease Law or any state or Governmental Agency, or medication furnished by any other Drug or Medical service for which no charge is made to the Member*
- *Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order*

For more information about NHP's Preferred Drug List call Customer Care at 800-462-5449, TTY 800-655-1761, or visit our Web site at www.nhp.org.

1. Covered in certain circumstances under the Durable Medical Equipment (DME) benefit.

2. Covered in certain circumstances under medical benefit.

Section 7.
Your NHP Covered Healthcare Services

To be covered by NHP, all Health Care Services and supplies must be:

- *Provided by or arranged by the Member's Primary Care Provider or NHP in-plan Specialist, unless noted otherwise in this Handbook.*
- *Authorized by NHP when Authorization is required. For further information on authorization requirements, check with your PCP, your NHP network Provider or contact the NHP Customer Care Center at 800-462-5449 or TTY 800-655-1761. You should always check with your PCP or treating provider to make sure that any required referrals or prior authorizations have been obtained before the services are performed or the supplies are provided. Failure to obtain necessary referrals or prior authorizations may result in Member liability for payment.*
- *Medically Necessary, as defined in this Handbook*
- *Listed as a Covered Health Care Service in this Handbook*
- *Provided by an NHP Network Provider, unless prior authorization has been obtained from NHP to see an out-of-network provider.*
- *Provided to an eligible Member enrolled in NHP. NHP is not responsible for payment of any services provided prior to a Member's Eligibility date or after a Member's NHP disenrollment date.*

If you have questions about your NHP benefits, please call the Customer Care Center at 800-462-5449 or TTY 800-655-1761.

The following are Covered Services for NHP Members.

Abortion

$100 Outpatient Surgery Copayment per occurrence with a cap of 4 Copayments per calendar year and $250 Inpatient Hospital Care Copayment per admission with a cap of 4 Copayments per calendar year.*

NHP covers abortion when services are obtained from an NHP Provider. You do not need a Referral from your Primary Care Provider for abortion services that are performed in a contracted Reproductive Health Service Facility. You may call the NHP Customer Care Center at 1-800-462-5449 (TTY 1-800-655-1761) for assistance in finding an NHP Provider.

Acute Hospital Care

$250 per admission with a cap of 4 Copayments per calendar year*

NHP covers acute care Hospital services when Medically Necessary. Your Primary Care Provider must arrange acute care Hospital services.

Ambulatory/Day Surgery

$100 per occurrence with a cap of 4 Copayments per calendar year

NHP covers Medically Necessary Outpatient surgical and related diagnostic and medical services. Your Primary Care Provider must arrange Ambulatory/Day Surgery services.

Blood and Blood Products

$0 Copayment

NHP covers administrative fees, supplies for administration, and self-donations for whole blood and its derivatives, including Factor 8, Factor 9 and immunoglobulin.

Blood Glucose Monitoring Strips

(Also see "Diabetic Services and Supplies")

NHP provides coverage for blood glucose monitoring strips when a Provider has issued a written order and when Medically Necessary for the treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes (also see Diabetic Services and Supplies in this section).

CAD Secondary Prevention Program

$0 Copayment

NHP offers a Coronary Artery Disease (CAD) Secondary Prevention Program to all NHP members enrolled through the Group Insurance Commission.

Members with documented coronary artery disease are potentially eligible for this program to help participants reduce Coronary Artery Disease risk factors through lifestyle changes. For more information on the CAD program, please contact NHP Case Management at 617-772-5500.

Cardiac Rehabilitation Coverage

$0 Copayment

NHP covers outpatient cardiac rehabilitation when Medically Necessary. Cardiac rehabilitation is defined as multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, which is provided in either a Hospital or other setting which meets the standards promulgated by the Commissioner of the Department of Public Health. Your Primary Care Provider and/or NHP Treating Provider must arrange for cardiac rehabilitation.

Cosmetic Surgery – Acne-Related Services

(Also see "Reconstructive/Restorative Surgery")

No benefits for cosmetic surgery or acne-related surgical services are provided. See Reconstructive/Restorative Surgery benefit.

Clinical Trials

NHP provides coverage of patient care services furnished pursuant to qualified clinical trials intended to treat cancer to the same extent as the coverage would be provided if the care were not being provided in a qualified clinical trial. Your primary care provider or treating provider in consultation with your primary care provider must obtain prior authorization for your participation in a clinical trial. A "qualified clinical trial" must meet the following conditions to be covered by NHP:

1. *The clinical trial is intended to treat cancer in a patient who has been so diagnosed.*
2. *The clinical trial has been peer reviewed and is approved by one of the United States National Institutes of Health, a cooperative group or center of the National Institutes of Health, a qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants, the United States Food and Drug Administration pursuant to an investigational new drug exemption, the United States Departments of Defense or Veterans Affairs, or, with respect to Phase II, III and IV clinical trials only, a qualified institutional review board.*

3. *The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise.*

4. *With respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility, and the clinicians conducting the trial shall have staff privileges at said academic medical center.*

5. *The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.*

6. *The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.*

7. *The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.*

8. *The clinical trial does not unjustifiably duplicate existing studies.*

9. *The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.*

Cytologic Screening (Pap smears)

$0 Copayment

NHP covers an annual cytologic screening for women eighteen years and older (or upon physician recommendation).

Dental Services – Emergency

$25 /$100/$250 Copayment*

NHP covers Emergency dental care and oral surgery within 72 hours of an accidental injury to the mouth and natural sound teeth only when performed by a physician or oral surgeon. Go to the nearest Emergency facility or call 911 or the emergency phone number in your area.

Dental Services – Other

$100 Copayment for Surgical Day Care services or $250 Copayment for Hospital Inpatient Care limited to four (4) Copayments per calendar year.

Removal of 7 or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, gingivectomies of two or more gum quadrants. Note: Benefits are provided for the dental services listed only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.

Diabetic Services and Supplies

NHP will provide coverage for Medically Necessary services and supplies used in the treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes. Services and supplies must be prescribed by an authorized health care professional. The following services and supplies are covered for a minimum thirty (30) day supply (with the exception of an insulin pump) within the following categories of benefits:

- *Outpatient Services: outpatient diabetes self-management training and education,*

including medical nutrition therapy: $25 Copayment

- *Laboratory/radiological services: lab tests and urinary profiles: $0 Copayment*
- *Durable Medical Equipment (DME): blood glucose monitors, voice-synthesizers for blood glucose monitors and visual magnifying aids for use by the legally blind: 20% Copayment of Purchase Price or Rental Cost.*
- *Prosthetics: therapeutic/molded shoes and shoe inserts: $0 copay.*
- *Prescription drugs: blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, syringes, pumps and pump supplies, insulin pens, insulin and oral medications.*
- *Select Diabetic Drugs and Supplies: 30-day supply, and when prescribed by NHP participating provider:*

  $10 generic
  (30 day supply)

  $25 brand name preferred
  (30 day supply)

  $45 brand name non-preferred
  (30 day supply)

Dialysis

$0 Copayment

NHP covers kidney dialysis on an Inpatient or Outpatient basis, or at home. You must apply for Medicare when federal law permits Medicare to be the primary payor for dialysis. You must also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled) NHP will pay for services only to the extent payments would exceed what would be payable by Medicare. Your Primary Care Provider must arrange dialysis services. If you are temporarily outside the Service Area, NHP covers limited dialysis services. You must make prior arrangements with your Primary Care Provider, who must obtain NHP approval for this coverage except in an Emergency.

Disposable Medical Supplies

$0 Copayment

NHP covers disposable medical supplies that are: necessary to meet a medical or surgical purpose and are nonreusable and disposable. This includes hypodermic syringes or needles. Your Primary Care Provider must order disposable medical supplies.

Durable Medical Equipment (DME)

20% Copayment of Purchase Price or Rental Cost

NHP covers Durable Medical Equipment that is: a) used to fulfill a medical purpose, b) generally not useful in the absence of illness or injury, and c) can withstand repeated use over an extended period of time, and is appropriate for home use. Coverage includes but is not limited to the purchase of medical equipment, replacement parts, and repairs. Your Primary Care Provider must order Durable Medical Equipment. Equipment not covered includes exercise bicycles, physiotherapy equipment and foot orthotics except for children 15 and under with symptomatic flat feet and pronation.

Early Intervention Services

$0 Copayment

NHP covers Early Intervention services for Members under the age of three (3) when the Member meets established criteria. NHP pays up to $5,200 per child, per calendar year, up to an aggregate benefit $15,600 over the total enrollment period. Such Medically Necessary Services may be provided by early intervention Specialists who are working in early intervention programs approved by the Massachusetts Department of Public Health. You may go to any NHP Early Intervention Provider for these services.

Educational/Psychological Testing and Therapy

Also See "Mental Health"

Diagnostic examinations or services requested for educational purposes or for use in an educational or developmental program are covered only as described in "Mental Health Section, Mental-Health-Related Alcohol or Chemical Dependency Treatment."

Emergency Services

Care you receive in an Emergency when you can't call your NHP doctor in advance: $75 Copayment when you call your doctor within 48 hours.

Care you receive for injuries or sudden illnesses when out of the NHP Service Area: $75 Copayment when you call your doctor within 48 hours.

NHP covers all Medically Necessary Emergency services. An Emergency is defined as a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. You do not need a Referral from your Primary Care Provider for Emergency Services. Go to the nearest Emergency facility or call 911 or the emergency phone number in your area. When a Member is admitted to a non-Plan affiliated Hospital due to an Emergency illness or accident and has received authorization to be compensated for necessary expenses, authorization to receive treatment at the non-Plan-affiliated Hospital will end when it is determined by a Plan Provider that the Member is able to travel to the nearest Plan-affiliated facility.

Eye Care – Examinations (Vision Care)

Same as Primary Care Copayment for your primary care provider

NHP covers routine eye exams for Members once every 24 months. Routine eye exams do not require a Referral from your Primary Care Provider. Go to any NHP Network ophthalmologist or optometrist for these services. For all other non-routine eye care services (difficult vision, blurry vision, loss of vision), you must see your Primary Care Provider who will arrange a referral to an ophthalmologist (eye care specialist). There is no coverage for eyeglasses or contact lenses (except when medically necessary for certain eye conditions such as treatment of keratoconus and following cataract surgery in which cases one pair per prescription change is covered), low vision aids (except for visual magnifying aids used by legally blind members with diabetes) or ocular prostheses.

Family Planning Services

$25 Copayment

NHP covers consultations, examinations, procedures and other medical services provided on an outpatient basis and related to the use of all FDA approved contraceptive methods including but not limited to lab tests, birth control counseling, pregnancy testing, voluntary sterilization, IUDs, diaphragms, and Norplant. You can obtain services from your Primary Care Provider, OB/GYN, Planned Parenthood, or any other NHP Provider who offers these services. All FDA-approved prescription contraceptive methods are covered. Contraceptive services are covered under the same terms and conditions as for other outpatient services and prescription drugs.

Gynecologic/Obstetric Care

****Tier 1 (excellent): $15 Copayment,*
***Tier 2 (good): $25 Copayment,*
**Tier 3 (standard): $35 Copayment*

NHP covers Medically Necessary gynecological and obstetrical services. You are not required to obtain a Referral or prior authorization for the following care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in NHP's health care Provider Network:

- *Annual preventive gynecologic health examinations and Medically Necessary follow-up;*
- *Maternity care; and,*
- *Acute or Emergency gynecologic examinations and resultant Medically Necessary health care services.*

Hearing Examinations

Same as Primary Care Copayment for your primary care provider

NHP covers comprehensive exams and evaluations performed by a hearing Specialist. Go to any NHP Provider for these services. NHP also provides coverage for the cost of a newborn hearing-screening test performed before the infant is discharged from the hospital or birthing center.

Hearing Aids

$0 Copayment

NHP covers hearing aids at no charge up to the first $500; 20% of purchase price of the next $1,500 to a maximum benefit of $1,700 per person per 2-year period.

Home Health Care

$0 Copayment

NHP covers home health care according to a physician-approved home health care plan when such care is an essential part of medical treatment and there is a defined goal. Home health care services are provided in a patient's residence by a public or private home health agency. Services include, but are not limited to, nursing and Physical Therapy; Occupational Therapy, Speech Therapy, medical social work, and nutritional consultation, the services of a home health aide and the use of Durable Medical Equipment (DME) and supplies if medical necessary. Your Primary Care Provider or NHP Treating Provider must arrange services.

Home Infusion

$0 Copayment

NHP covers home infusion services. Your Primary Care Provider or NHP Treating Provider must arrange home infusion services.

Hormone Replacement Therapy

NHP provides coverage for hormone replacement therapy services including outpatient prescription drugs for peri- and post-menopausal women under the same terms and conditions as for other outpatient services and prescription drugs (refer to "Pharmacy" in this section for more information).

Hospice

$0 Copayment

NHP covers hospice care for terminally ill Members with a life expectancy of six (6) months or less provided such services are determined to be appropriate and authorized by the Member's Primary Care Provider and are equivalent to those services provided by

a licensed hospice program regulated by the Department of Public Health.

House Calls

Same as Primary Care Copayment for your primary care provider

NHP covers house calls within the NHP Service Area when Medically Necessary. Providers include Primary Care Providers, Nurse Practitioners and physicians' assistants. Your Primary Care Provider must arrange for house calls.

Immunizations, Vaccinations

Same as Primary Care Copayment for your primary care provider

NHP covers immunizations when part of an office visit.

Infertility Treatment

$25 Office Visit Copayment; $100 Outpatient Surgery Copayment per occurrence with a cap of 4 Copayments per calendar year and $250 Inpatient Copayment per admission with a cap of 4 Copayments per calendar year.*

NHP will cover Medically Necessary expenses for the diagnosis and non-experimental treatment of infertility (the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year) to the same extent that benefits are provided for other Medically Necessary services and prescription medications. The following procedures are covered, but not limited to:

- *Artificial Insemination (AI);*
- *In Vitro Fertilization and Embryo Placement (IVF);*
- *Gamete Intra-Fallopian Transfer (GIFT);*
- *Zygote Intrafallopian Transfer (ZIFT);*
- *Intracytoplasmic Sperm Injection (ICSI);*
- *Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any (insurers may not limit Coverage to sperm provided by the spouse);*
- *Assisted Hatching.*

NHP does not provide coverage for:

- *Any experimental infertility procedure;*
- *Surrogacy/gestational carrier;*
- *Reversal of voluntary sterilization; or,*
- *Cryopreservation of eggs.*

Institutional Extended Care

(Skilled Nursing Facility care, Rehabilitation Facility care, Chronic Hospital care):

NHP covers care in an extended care facility, such as a skilled nursing facility or rehabilitation facility, up to the benefit limit described on the Summary of Benefits only when you need daily skilled nursing care or rehabilitative services that must be provided in an inpatient setting. Your Primary Care Provider must arrange institutional extended care services.

Skilled Nursing Facility or Chronic Care Hospital

$0 Copayment for up to 100 days per calendar year – Medical Benefit

Rehabilitation Facility

$250 Copayment Per Admission with a cap of 4 Copayments per calendar year – Medical Benefit*

Laboratory Services

$0 Copayment

NHP covers services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of the Member.

Mammographic Examination (Mammogram)

$0 Copayment

NHP covers baseline Mammograms for women between age of thirty-five (35) and forty (40) and an annual Mammogram for women forty (40) and older.

Maternity Services – General Coverage

NHP provides inpatient and outpatient maternity benefits for the expense of prenatal care, childbirth, and post-partum care to the same extent as provided for medical conditions not related to pregnancy. NHP provides coverage for services rendered by an obstetrician, pediatrician, or certified nurse midwife attending the mother and child.

Maternity Services – Inpatient

$250 per admission with a cap of 4 Copayments per calendar year*

NHP covers inpatient maternity care provided by an attending obstetrician, pediatrician, or certified nurse midwife for a mother and newborn child for at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother and physician agree to an early discharge, Covered Health Care Services include one home visit by a registered nurse, physician, or certified midwife, and additional home visits when Medically Necessary and provided by an NHP Provider. There is no coverage for delivery outside the Service Area within 30 days of the expected delivery date, or after the Member has been told that she is at risk for early delivery. Your Primary Care Provider, obstetrician, or certified nurse midwife must arrange for services.

Maternity Services – Outpatient

Same as Gynecological/Obstetric Care (see page 44)

NHP covers prenatal and postpartum care for Members when care is received from an NHP Provider. Services include prenatal exams; diagnostic tests; prenatal nutrition; childbirth education (NHP reimburses members up to $90 for childbirth classes for the member's first pregnancy and up to $45 for a member's refresher course); health care counseling; risk assessment; and postpartum exams. There is no coverage for obstetrical care outside the NHP Service Area within thirty (30) days of expected delivery date. Your Primary Care Provider, obstetrician, or certified nurse midwife must arrange for outpatient maternity services.

Mental Health and Substance Abuse Benefits

(See Page 54 for details)

Newborn Care

$0 Copayment

NHP covers all Medically Necessary newborn care. Your Primary Care Provider must arrange newborn care.

Non-durable Medical Equipment and Supplies

$0 Copayment

Non-Durable Medical Equipment and supplies are covered only when used in the course of diagnosis or treatment in a medical facility or in the course of authorized home care.

Nutritional Formulas

$0 Copayment

NHP provides coverage for nutritional formula in the following situations:

1. *Formulas, approved by the Commissioner of the Department of Public Health, for the treatment of infants and children with specific inborn errors of metabolism of amino acids and organic acids such as phenylketonuria (PKU), tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia and methylmalonic acidemia;*

2. *Formulas, approved by the Commissioner of the Department of Public Health as Medically Necessary to protect the fetuses of pregnant women with phenylketonuria;*

3. *Formulas for the treatment of malabsorption caused by disorders affecting the absorptive surface, functional length, gastrointestinal tract motility, such as Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility and chronic intestinal false-obstruction;*

4. *Formulas for the treatment of members with an anatomic or structural problem that prevents food from reaching the stomach (e.g. esophageal cancer), or a neuromuscular problem that results in swallowing or chewing problems (e.g. muscular dystrophy);*

5. *Formulas for the treatment of members with a serious medical condition that either directly or indirectly impacts their ability to normally ingest regular foods and places them at substantial risk of malnutrition (e.g. cancer, AIDS, organ failure, etc.); and*

6. *Formulas for the treatment of pediatric members diagnosed with failure to thrive.*

Coverage for inherited diseases of amino acids and organic acids includes food products modified to be low protein in an amount not to exceed $2500 annually.

Obstetrical Services

(See Gynecologic/Obstetric Services)

Off-Label Use of Drugs for the Treatment of Cancer

Copayment for each prescription drug is: $10 Generic – 30 day supply; $25 brand name preferred – 30 day supply; and $45 brand name non-preferred – 30 day supply.

NHP provides coverage for use of off-label drugs in the treatment of cancer as it would for any covered prescription drug. The drug must be recognized for treatment of cancer in one of the standard reference compendia, or in the medical literature, or by the Commissioner of Insurance. In addition, NHP will provide coverage for a drug indicated for the treatment of cancer within the Association of Community Cancer Centers Compendia-Based Drug Bulletin. Your Primary Care Provider or NHP Specialist must arrange for this service.

Off-Label Use of Drugs for the Treatment of HIV/AIDS

Copayment for each prescription drug is: $10 Generic – 30 day supply; $25 brand name preferred – 30 day supply; and $45 brand name non-preferred – 30 day supply.

NHP provides coverage for use of off-label drugs in the treatment of HIV/AIDS as it would for any covered prescription drug. The drug must be recognized for treatment of HIV/AIDS in one of the standard reference compendia, or in the medical literature, or by the Commissioner of Insurance. Your Primary Care Provider or NHP Specialist must arrange for this service.

Optometric/Ophthalmologic Care

(See "Eye Care")

Orthotics

$0 Copayment

NHP covers non-dental braces and other mechanical or molded devices when Medically Necessary to support or correct any defects of form or function of the human body due to surgery, disease or injury. Your Primary Care Provider must arrange these services. Orthotics/Support Devices for Feet: Support devices for the feet and corrective shoes are only covered for children fifteen (15) and under with certain medical conditions such as pronation or when prescribed by the Member's PCP and authorized by NHP.

Oxygen Therapy

$0 Copayment

NHP covers oxygen therapy for Members who have severe hypoxia as demonstrated by oxygen saturation levels. Coverage includes oxygen and equipment rental and supplies required to deliver the oxygen. Your Primary Care Provider must arrange oxygen therapy services.

Pediatric Specialty Care

Non-Tiered Specialist: $25 Copayment
Mental Health Specialist: $10 Copayment

NHP provides Coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in providing specialty pediatric care.

Pharmacy

Pharmacy benefits are offered under your GIC Coverage. NHP covers up to a thirty (30) day supply at one time of any covered prescription drug prescribed by an NHP Provider. Oral contraceptives and diaphragms are covered under this benefit. Some smoking deterrent drugs are also covered up to 90 days per contract year. Some drugs require prior authorization from NHP. All covered prescription medications require a prescription from your PCP or NHP Provider. Prescription quantities are limited to a 30-day supply. Generic substitution is mandatory whenever available. Be sure to show your NHP Member ID Card to the pharmacist at an NHP Participating Pharmacy.

Prescription Drugs: No more than a thirty (30) day supply of each prescription item except that up to a one hundred (100) unit dose may be dispensed to a Member for a chronic condition when prescribed by an NHP physician. Prescription refills shall not be permitted for more than a twelve (12) consecutive month period from the date of the original prescription. Following such twelve (12) month period a new prescription ordered by an NHP physician or a physician to whom a Member is referred by a NHP physician shall be required. The Copayment for each prescription drug is:

$10 Generic
(30 day supply)

$25 brand name preferred
(30 day supply)

$45 brand name non-preferred
(30 day supply)

Mail order pharmacy benefit for maintenance drugs as described in Pharmacy Benefit by Mail brochure:

$20 Generic
(90 day supply)

$50 brand name preferred
(90 day supply)

$135 brand name non-preferred
(90 day supply)

Over-the-Counter (OTC) Medications:

$0 to $45 Copayment

Some over-the-counter medications are covered when ordered by an NHP Provider, such as generic versions of cough and cold medicines, allergy medicines, pain medications and insulin and diabetic supplies. The generic equivalents of certain products may be covered with $0 Copayment. Please refer to the NHP website at www.nhp.org or contact Customer Care at 1-800-462-5449 (TTY 1-800-655-1761) for specific information on which products are covered.

Physician Services

****Tier 1 (excellent): $10 Copayment, **Tier 2 (good): $20 Copayment, *Tier 3 (standard): $25 Copayment for Outpatient Medical Care. $0 Copayment for Inpatient Hospital Care.*

NHP covers diagnosis, treatment, consultation, and minor surgery when provided by the Member's Primary Care Provider or when referred to a NHP Provider. Your Primary Care Provider must arrange these services.

Podiatry Services

$25 Copayment

NHP covers Medically Necessary podiatry services whether the service is performed by a physician or duly licensed podiatrist. Your Primary Care Provider must arrange podiatry services.

Preventive/Primary Care Services for Children

****Tier 1(excellent): $10 Copayment, **Tier 2 (good): $20 Copayment, *Tier 3 (good): $25 Copayment*

NHP will cover for the following services to the Dependent child of an Insured Member from the date of birth through age six (6):

1. *Physical examinations, history, measurement, sensory screening, neuropsychiatric evaluations and development screening, and assessment at the following intervals: six times during the child's first year after birth, three (3) times during the next year, and annually until age six (6).*
2. *Coverage for newborn hearing screening test (see Hearing Exams).*
3. *Hereditary and metabolic screening at birth: appropriate immunizations; tuberculin test, hematocrit, hemoglobin or other appropriate blood tests and urinalysis, as recommended by the physician, and lead screening pursuant to Massachusetts state law.*

NHP covers injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities or premature birth.

1. *Coverage includes those special medical formulas approved by the Commissioner of the Department of Public Health, prescribed by a physician, and that are Medically Necessary to protect unborn fetuses or pregnant women with phenylketonuria.*

Prosthetic Devices

$0 Copayment

NHP covers prosthetic devices, including evaluation, fabrication, and fitting. Coverage includes prosthetic devices which replace in whole or in part, an arm or leg, and any repairs. Your Primary Care Provider must arrange prosthetic device services.

Radiation and Chemotherapy

NHP covers radiation and chemotherapy by a network provider when arranged by your Primary Care Provider.

Radiology

$0 Copayment

NHP covers all radiological services including X-rays, MRIs and CAT scans. Your Primary Care Provider must arrange radiology services.

Reconstructive/Restorative Surgery

$100 Outpatient Surgery Copayment per occurrence with a cap of 4 Copayments per calendar year and $250 Inpatient Hospital Care Copayment per admission with a cap of 4 Copayments per calendar year.*

Reconstructive surgery is any procedure to repair, improve, restore or correct bodily function caused by an accidental injury, congenital anomaly or a previous surgical procedure or disease. NHP covers surgery for post-mastectomy coverage including:

- *Reconstruction of the breast on which the mastectomy was performed;*
- *Surgery and reconstruction of the other breast to produce symmetrical appearance, and;*
- *Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.*

Your Primary Care Provider must arrange reconstructive / restorative surgery services.

Registered Nurse or Nurse Practitioner

Same as Primary Care Copayment for your primary care provider

NHP covers services rendered by a registered nurse, nurse Practitioner, nurse midwife or nurse anesthetist if such services are within the nurse's scope of practice. Your Primary Care Provider must arrange these services.

Rehabilitation Therapy (Physical and Occupational)

$25 Copayment

NHP covers evaluation and restorative, short-term treatment when needed to improve the ability to perform Activities of Daily Living and when there is likely to be significant improvement in the Member's level of function after illness or injury. Coverage includes Occupational Therapy and Physical Therapy up to ninety (90) days per acute episode. Initial evaluations for outpatient rehabilitation therapy do not require a Referral. Go to any NHP Provider of these services. Your Primary Care Provider must arrange all other rehabilitation therapy services, including ongoing treatment plans. Refer to your Summary of Benefits for any limitation on Physical or Occupational Therapy.

Routine Examinations

Same as Primary Care Copayment for your primary care provider

NHP covers routine physical exams (for example, well-child care, premarital exams, school and sports exams) as appropriate for Member's age and gender, as well as care when a Member is sick. Cytologic screening (Pap smears) and mammographic examinations are covered as outlined in this section.

Second Opinions

$25 Copayment

NHP covers second opinions when provided by another NHP Provider. Second opinions from Out-of-Network Providers are covered only when the specific expertise requested is not available within the Network. Prior authorization from NHP is required.

Specialty Care (Cardiology, Endocrinology, Gastroenterology, OB/GYN, Orthopedics, Rheumatology)

****Tier 1 (excellent): $15 Copayment, **Tier 2 (good): $25 Copayment, *Tier 3 (standard): $35 Copayment for Outpatient Medical Care.*

Specialty Care (All Other)

$25 Copayment

You are not required to obtain a Referral or prior authorization for the following care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in NHP's health care Provider Network:

- *Annual preventive gynecologic health examinations and Medically Necessary follow-up;*
- *Maternity care; and*
- *Acute or Emergency gynecologic examinations.*

Speech, Hearing and Language Disorders

$25 Copayment

NHP provides coverage for the diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists. Coverage is provided if services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists, regardless of whether the services are provided in a Hospital, clinic or a private office. Coverage does not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting. Benefits provided are subject to the same terms and conditions established for any other medical condition covered under individual or group insurance policies. Initial evaluations for outpatient speech therapy do not require a Referral. Go to any NHP Provider of these services. Your Primary Care Provider must arrange all other speech therapy services, including ongoing treatment plans.

Surgery

NHP provides coverage for medically necessary surgery including related anesthesia, circumcision, cosmetic surgery to restore bodily function or correct functional physical impairment following an accidental injury, prior surgery or congenital/birth defect and voluntary sterilization.

Transplants

$100 Outpatient Surgery Copayment per occurrence with a cap of 4 Copayments per year and $250 Inpatient Hospital Care Copayment per admission with a cap of 4 Copayments per year.*

NHP covers transplants as follows:

- *Bone marrow transplants are covered when provided within the NHP network and approved by NHP. Coverage includes but is not limited to Members with breast cancer that has progressed to metastatic disease, provided that the Member meets criteria established by the Department of Public Health.*
- *Human organ transplants are covered. Transplants must be non-experimental surgical procedures provided within the NHP Network and approved by the NHP Medical Director. Coverage includes donor's costs for both living and nonliving transplant donors to the extent that another insurer does not cover the charges.*
- *Coverage for Human Leukocyte Antigen Testing for Certain Individuals and Patients. NHP will provide for all Members or enrollees coverage for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish such Member's or enrollee's bone marrow transplant donor*

suitability. The coverage includes the cost of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health. Your Primary Care Provider must arrange all services.

Transportation

$0 Copayment

Except in an Emergency, ambulance transportation is covered only when arranged by an NHP Provider. NHP covers such ambulance transport to the nearest Hospital that can provide the care you need. We also cover Medically Necessary transfer from one health care facility to another.

Urgent Care

Same as Primary Care Copayment for your primary care provider

Examples of conditions requiring Urgent Care include but are not limited to fever, sore throat, earache and acute pain. Your Primary Care Provider must arrange for Urgent Care. Urgent care outside the NHP Service Area is covered when you notify your Primary Care Provider within 48 hours after receiving care. Urgent Care does not include care that is provided in an emergency room or care that is elective, Emergency, preventive or health maintenance.

Vision Care

See "Eye Care"

Wigs (Scalp Hair Prosthesis for Cancer Patients)

20% Coinsurance

For hair loss suffered as a result of the treatment of any form of cancer or leukemia, a written statement by the treating physician that the wig is Medically Necessary is required. In addition, this benefit is

- *Subject to the same limitations and guidelines as other prostheses; and is*
- *Limited to $350 per year.*

**Per admission / occurrence with a cap of four (4) copayments per calendar year. Copayment will be waived for re-admission to a hospital for any reason if the re-admission occurs within 30 days of release from a hospital. The hospital inpatient copayment is not automatic. You must contact NHP to have the copayment waived.*

Section 8.
Mental Health and Substance Abuse Services

Mental Health and Substance Abuse Services (General)

NHP's mental health and substance abuse (MH/SA) treatment benefits includes non-custodial, inpatient, intermediate and outpatient services based on medical necessity criteria for treatment in the least restrictive, clinically appropriate setting. NHP does not apply any Copayments, deductibles, coinsurance or maximum lifetime benefits to mental health and substance abuse services that are not equally applied to other covered health care services. Beacon Health Strategies (Beacon) is NHP's delegated Managed Behavioral Health Organization (MBHO). All authorizations including adverse determinations for behavioral health services are made only by licensed mental health professionals. Beacon has established contracts with a network of clinicians, groups, clinics and practices to provide mental health and substance abuse treatment services within the NHP service area.

All mental health or substance abuse services must be provided by an NHP / Beacon contracted provider within the network. You may call Beacon Health Strategies for immediate information and assistance in locating the services you are seeking. You can also ask your Primary Care Provider to refer you to an NHP / Beacon participating provider.

NHP Members can call Beacon at 800-414-2820 or TTY 781-994-7660. You can also find information at their web site, www.beaconhealthstrategies.com.

NHP provides benefits for the diagnosis and treatment of mental disorders described in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (DSM). The amount and type of treatment provided under the NHP benefits are determined by medical necessity, and may be subject to authorization requirements. All Copayments and coverage limits are described in your Benefit Summary.

NHP provides coverage for the diagnosis and treatment of:

- *Biologically-based Mental Health Conditions and non-biologically based mental, behavioral, or emotional disorders, including Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, panic disorder, obsessive-compulsive disorder, delirium and dementia, affective disorders, and other psychotic disorders or other biologically-based mental disorders appearing in the Diagnostic and Statistical Manual (DSM) that are scientifically recognized.*
- *Rape related mental or emotional disorders to victims of rape or victims of assault with intent to commit rape. Rape-related Mental health treatment is based on medical need for the service without any predetermined annual or lifetime or annual dollar or unit limitation.*
- *Non-biologically-based mental, behavioral or emotional disorders, in children and adolescents under the age of 19, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent, including, but not limited to: (1) an inability to attend school as a result of such a disorder, (2) the need to hospitalize the child or adolescent as a result of such a disorder, (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. NHP will continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to subsequent benefits*

which are in effect." Treatment is based on medical need for the service.

- *Alcohol and drug addiction treatment.*
- *Psychopharmacological and neuropsychological assessments. Treatment is based on medical need for the service.*

Mental Health and Substance Abuse Services (Outpatient)

NHP Members may directly seek outpatient mental health and substance abuse counseling or medication services from any clinician in the NHP / Beacon statewide Network. The Network includes physicians with a specialty in psychiatry, licensed psychologists, licensed independent clinical social workers, licensed mental health clinical nurse specialists or licensed mental health counselors. Members may directly contact in network providers of these services for treatment. A referral from your Primary Care Provider is not required. Your first eight (8) outpatient sessions, in each calendar year, including medication evaluation and management, do not require a clinical review for medical necessity. However, if additional outpatient sessions are necessary, your mental health provider is required to contact Beacon to obtain an authorization.

All authorizations are based on the medical necessity and the Member's clinical needs. All Copayments for outpatient mental health or substance abuse services, if applicable, are included in your Benefit Summary. Biologically-based mental health services are provided without annual, lifetime or visit/unit/day limitations. Your policy may have an annual limit for non-biologically based services. No other limitations, coinsurance, co-payment, deductible or other cost-sharing may be applied toward these benefits except as are applied to covered medical services within the plan. Please see your Benefit Summary to determine if your benefits include an annual limit or contact NHP's Customer Care Center at 800-462-5449 or TTY 800-655-1761

Services may be provided in a licensed hospital; a mental health or substance abuse clinic licensed by the Department of Mental Health or Public Health; a community mental health center; a professional office or home-based service, provided, however, services are rendered by a licensed mental health professional acting within the scope of his or her license.

Mental Health and Substance Abuse Services (Intermediate)

NHP covers medically necessary Intermediate Mental Health and Substance Abuse services. Services include partial hospitalization; structured outpatient addiction program; community based acute treatment programs; community based detoxification; family stabilization; community support; addiction day treatment for pregnant women and psychiatric day treatment. To obtain services, call Beacon Health Strategies at 800-414-2820 or TTY 781-994-7660. You may also contact your Primary Care Provider for assistance. You or your Behavioral Health Provider must obtain prior authorization from Beacon Health Strategies for these services which must be provided by network providers.

Mental Health and Substance Abuse Services (Inpatient)

Services may be provided in a general hospital licensed to provide such services; in a facility under the direction and supervision of the Department of Mental Health; in a private mental hospital licensed by the Department of Mental Health; or in a substance abuse facility licensed by the Department of Public Health. Inpatient services are a 24 hour service, delivered in a license hospital setting for mental health or substance abuse treatment.

To obtain services, call Beacon Health Strategies at 800-414-2820 or TTY 781-994-7660. You may also contact your Primary Care Provider or Hospital Emergency Room for assistance. You or your Behavioral Health Provider must obtain prior authorization from Beacon Health Strategies for these services which must be provided by network providers.

MH\SA Summary of Copayments

Outpatient Care Mental / Substance Abuse rehabilitation
$10 per Office Visit

Outpatient Substance Abuse detoxification
$10 per Office Visit

Inpatient Care Mental Health Care at a psychiatric Hospital
$0 Copayment per MH Admission

Inpatient Substance Abuse rehabilitation
(at Inpatient Substance Abuse Treatment Facility)
$0 Copayment per Admission

Inpatient Substance Abuse detoxification
$0 Copayment per Admission

Intermediate Mental Health/Substance Abuse
$0 Copayment

Section 9.
Benefit Exclusions and Limitations

NHP does not cover the following services or supplies:

Acupuncture

Benefits From Other Sources
Health care services and supplies to treat an illness or injury for which you have the right to benefits under government programs. These include the Veterans Administration for an illness or injury connected to military service. They also include programs set up by other local, state, federal or foreign laws or regulations that provide or pay for health care services and supplies or that require care or treatment to be furnished in a public facility. In addition, no benefits are provided if you could have received governmental benefits by applying for them on time. Services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law.

Biofeedback

Blood and Related Fees
Blood or blood products except as specified in this Member Handbook under "Your Neighborhood Health Plan Benefits."

Chiropractic Care

Cosmetic Services and Procedures
Cosmetic Services that are performed solely for the purpose of making you look better, whether or not these services are meant to make you feel better about yourself or treat a mental condition. Such as surgery to treat acne lesions or remove tattoos. Also medications for cosmetic purposes to treat hair loss or wrinkles. Reconstructive surgery is covered. Note: As required by federal law, for a member who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy, benefits for reconstructive surgery include: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Custodial Care
Custodial or rest care. This is care that is furnished mainly to help a person in the activities of daily living, and does not require day-today attention by medically-trained persons.

Dental Care
No benefits are provided for routine dental care or dentures.

Dentures

Diet Foods
No benefits are provided for the purchase of special foods to support any type of diet, except for those nutritional supplements/ formulas specifically listed as a Covered Health Care Service in this Handbook.

Educational Testing and Evaluations
No benefits are provided for educational services or testing, except such services covered under the Early Intervention Services and Outpatient Mental Health and Substance Abuse benefit. No benefits are provided for educational services whose intent is solely to enhance educational achievement (e.g. subject achievement testing) or to resolve problems regarding school performance.

Exams Required by a Third Party
Physical, psychiatric and psychological examinations or testing required by a third party, including but not limited to employment; insurance; licensing and court-ordered or school-ordered exams and drug testing that are not Medically Necessary or are considered evaluations for work-related performance.

Experimental Services and Procedures
The benefits described in this Member Handbook are provided only when covered services are furnished in accordance with Neighborhood Health Plan's medical technology assessment guidelines. No benefits are provided for health care charges that are received for or related to care that NHP considers to be experimental services or procedures. The fact that a treatment is offered as a last resort does not mean that benefits will be provided for it. There are three exceptions to this exclusion. As required by law, Neighborhood Health Plan does provide benefits for:

1. *One or more stem cell ("bone marrow) transplants for a member who has been diagnosed with breast cancer that has spread. The member must meet the eligibility standards that have been set by the Massachusetts Department of Public Health;*

2. *Certain drugs used on an off-label basis. Some examples are: drugs used to treat cancer; and drugs used to treat HIV/AIDS and*

3. *Coverage of patient care services furnished pursuant to qualified clinical trials intended to treat cancer.*

Eyewear/Laser Eyesight Correction
No benefits are provided for eyeglasses and contact lenses. Benefits are also not provided for eye surgery to treat conditions which can be corrected by means other than surgery. An example of eye surgery that is excluded is laser surgery, for conditions such as nearsighted vision.

There is an exception to this exclusion. NHP does provide benefits for contact lenses when Medically Necessary for certain eye conditions, such as use for post-cataract surgery and the treatment of keratoconus.

Foot Care
Routine foot care services such as trimming of corns, trimming of nails and other hygienic care, except when your care is Medically Necessary due to systemic circulatory diseases (such as diabetes).

Gender Re-Assignment Surgery
Gender re-assignment surgery and all related drugs and procedures.

Massage Therapy
No benefits are provided for massage therapy.

Non-Covered Providers
Any service provided, arranged, or approved by a Provider other than the Member's Primary Care Provider or another NHP Provider. Also Medications or supplies prescribed by Providers not authorized to provide care by NHP, except as covered outside the NHP Service Area.

Other Non-Covered Services
Any service or supply that is not a described as a Covered Benefit in this Member Handbook. Including:

- *Any service or supply that is not Medically Necessary.*
- *A Provider's charge for shipping and handling or taxes.*
- *Medications, devices, treatments and procedures that have not been demonstrated to be medically effective.*
- *Routine care, including routine prenatal care, when the Member is traveling outside the NHP Service Area.*
- *Services for which there would be no charge in the absence of insurance.*
- *Special equipment needed for sports or job purposes.*
- *There is no coverage for delivery of a baby outside the NHP Service Area within thirty (30) days of the expected delivery date, or after the Member has been told that she is at risk for early delivery.*
- *Work rehabilitation.*

Personal Comfort Items

No benefits are provided for personal comfort or convenience items or services that are furnished for your personal care or for the convenience of your family. Some examples of non-covered items or services include: telephones, radios, televisions and personal care services. The following items are generally deemed convenience items:

- *Air conditioners*
- *Air purifiers*
- *Chair lifts*
- *Dehumidifiers*
- *Dentures*
- *Elevators*
- *"Spare" or "back-up" equipment.*
- *Bath/bathing equipment such as aqua massagers and turbo jets*
- *Whirlpool equipment generally used for soothing or comfort measures*
- *Home type bed baths requiring installation (such as Schmidt or Century Bed Bath).*
- *Non-medical equipment otherwise available to the member that does not serve a primary medical purpose.*
- *Bed lifters not primarily medical in nature.*
- *Beds and mattresses, non-hospital type (e.g., Beautyrest or Craft-matic brand adjustable beds)*
- *Bed, hospital type in Full, Queen and King sizes*
- *Cushions, pads and pillows except those described as covered*
- *Pulse Tachometers*

Reversal of Voluntary Sterilization

No benefits are provided for the reversal of voluntary sterilization.

Self-Monitoring Devices Limitation

No benefits are provided for self-monitoring devices except for:

- *Blood glucose monitoring devises used by members with insulin-dependent, insulin-using, gestational or non-insulin dependent diabetes; and*
- *Certain devices that Neighborhood Health Plan decides would give a member having particular symptoms the ability to detect or stop the onset of a sudden life-threatening condition.*
- *Peak flow meters used in the monitoring of asthma control.*

Section 10.
When You Have Other Coverage

The following information explains how benefits under this policy will be coordinated with other insurance benefits available to pay for health services that a Member has received. Benefits are coordinated among insurance Carriers to prevent duplicate payment for the same service. Nothing in this section should be interpreted to provide coverage for any service or supply that is not expressly covered under this Handbook or to increase the level of coverage provided.

Coordination of Benefits

Benefits under this Evidence of Coverage will be coordinated to the extent permitted by law with other plans covering health benefits including but not limited to homeowner's insurance, motor vehicle insurance, group and/or non-group health insurance, Hospital indemnity benefits that exceed $100 per day, and governmental benefits. Coordination of Benefits will be based upon the Massachusetts Regulation 211 CMR 38.00 for a service that is covered at least in part by any of the plans involved. NHP reimbursement shall not exceed the maximum allowable under the Plan.

Primary vs. Secondary Coverage

When a Member is covered by two or more health benefit plans, one plan will be "primary" and the other plan (or plans) will be "secondary." The benefits of the primary plan are determined before those of the secondary plan(s) and without considering the benefits of the secondary plan(s). The benefits of the secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits. In the case of health benefit plans that contain provisions for the Coordination of Benefits, the following rules shall decide which health benefit plans are primary or secondary:

Dependent/Non-Dependent: The benefits of the plan that covers the person as an employee or Subscriber are determined before those of the plan that covers the person as a Dependent.

A Dependent child whose parents/guardians are not separated or divorced: The order of benefits is determined as follows:

1. *The benefits of the plan of the parent/guardian whose birthday falls earlier in a year are determined before those of the plan of the parent or guardian whose birthday falls later in that year. If both parents or guardians have the same birthday, the plan covering the parent or guardian for the longer time is primary.*

2. *When the other plan does not have the same rules of priority as those listed above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine order of benefits.*

A Dependent child whose parents are separated or divorced: Unless a court order, of which NHP has knowledge, specifies one of the parents as responsible for the health care benefits of the child, the order of benefits is determined as follows:

1. *First, the plan of the parent with custody of the child;*
2. *Then, the plan of the spouse of the parent with custody of the child; and*
3. *Finally, the plan of the parent not having custody of the child.*

Active/Inactive Employee: The benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.

Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the benefits of the plan that covered

the employee, Member or Subscriber, longer are determined before those of the plan that covered that person for the shorter time. If a Member is covered by a health benefit plan that does not have provisions governing the Coordination of Benefits between plans, that plan will be the primary plan.

Provider Payment When NHP Coverage is Secondary

When a Member's NHP coverage is secondary to a Member's coverage under another health benefit plan, NHP may suspend payment to a Provider of services until the Provider has properly submitted a Claim to the primary plan and the Claim has been processed and paid, in whole or in part, or denied by the primary plan. NHP may recover any payments made for services in excess of NHP's liability as the secondary plan, either before or after payment by the primary plan.

Worker's Compensation/ Government Programs

If NHP has information indicating that services provided to a Member are covered under Worker's Compensation, employer's liability, or another program of similar purpose, or by a federal, state or other government agency, NHP may suspend payment for such services until a determination is made whether payment will be made by such program. If NHP provides or pays for services for an illness or injury covered under Worker's Compensation, employer's liability, or another program of similar purpose. Or by a federal, state or other government agency, NHP will be entitled to recovery of its expenses from the Provider of services or the party or parties legally obligated to pay for such services.

Subrogation

If you are injured by any act or omission of another person, the coverage under this contract will be subrogated. This means that NHP may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, you must reimburse NHP up to the amount of the payments that it has made. This is true even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than health care expenses. The amount you must reimburse NHP will not be reduced by any attorney's fees or expenses you incur. You must give NHP information and help. This means you must complete and sign all necessary documents to help NHP get this money back. This also means that you must give NHP notice before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which NHP provide coverage. You must not do anything that might limit NHP's right to full reimbursement. The Subrogation and recovery provisions in this Evidence of Coverage apply whether or not the Member recovering money is a minor. To enforce its Subrogation rights under this policy, NHP will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by the Plan for which such party is, or may be, liable.

Member Cooperation

As a Member of NHP, you agree to cooperate with NHP in exercising its rights of Subrogation and Coordination of Benefits under the Evidence of Coverage. Such cooperation will include, but not be limited to:

- *The provision of all information and documents requested by NHP;*

- *The execution of any instruments deemed necessary by NHP to protect its rights;*
- *The prompt assignment to NHP of any monies received for services provided or paid for by NHP;*
- *The prompt notification to NHP of any instances that may give rise to NHP's rights.*

The Member further agrees to do nothing to prejudice or interfere with NHP's rights to Subrogation or Coordination of Benefits. Failure of the Member to perform the obligations stated in this section shall render the Member liable to NHP for any expenses NHP may incur, including reasonable attorneys' fees, in enforcing its rights under this Plan. Nothing in this Member Handbook may be interpreted to limit NHP's right to use any means provided by law to enforce its rights to Subrogation or Coordination of Benefits under this plan.

Section 11.
Care Management Programs

If you have a complex health concern, NHP has care managers who can support you and your healthcare Provider during treatment. Our care managers are nursing and therapy professionals (e.g. physical, respiratory, etc.) who have expertise helping individuals who have a range of health care needs. Care management can be provided for diabetes, smoking cessation (help to stop-smoking), asthma, Behavioral Health (mental health and substance abuse), complex care needs, injuries requiring rehabilitation, organ transplant patients, and chronic illnesses. Below is a list of some of our care management programs. Members may join any of the programs. For additional information on these or additional programs:

- *Refer to your Healthy Options booklet in your Member kit;*
- *Call NHP's Customer Care Center at 800-462-5449 (or TTY 800-655-1761);*
- *Visit NHP's website at www.nhp.org; or*
- *Call one of our Care Managers toll free at 800-432-9449.*

Asthma Management Program

NHP's Asthma Program helps you better manage your asthma by making sure you get all the care you need. An Asthma Care Manager will work with you and your healthcare Provider to come up with a treatment plan that works for you. A respiratory therapist can also visit you at home, help you understand how to use your medication, and help you identify what could be triggering asthma episodes. Educational books, videos, and a computer game that helps children understand asthma are also available.

Behavioral Health Care Program

NHP provides care for members who may have mental health and substance abuse concerns. NHP's Behavioral Health Care Management program is managed by Beacon Health Strategies. They can help find a counselor near you, make recommendations, and explain your treatment options. A referral from your doctor is not needed for these services. For more information about Behavioral Health benefits:

- *Call Beacon Health Strategies at 800-414-2820 or (TTY: 781-994-7660);*
- *Visit Beacon's Health Strategies' website at: www.beaconhealthstrategies.com;*
- *Call NHP's Customer Care Center: 800-462-5449 or (TTY 800-655-1761);*
- *Or visit the NHP website: www.nhp.org.*

Care Partnership Program

If you have complex care needs, or the potential for complex care needs, care managers work with you on developing health & wellness action plans, coaching and education, and collaborate with your Providers to coordinate your health care needs.

Diabetes Management Program

If you have diabetes, you may benefit from the extra care and education our Diabetes Care Management Program provides. Diabetes care managers reach out to Members considered to be at-risk for diabetes-related complications by providing education and support.

For You Two Prenatal Program

If you are pregnant, NHP's *For You Two* program provides you with information about pregnancy, plus educational material and extra support for moms-to-be. The *For You Two* program is free and offers you:

- *Help from an NHP care manager*
- *Rental or purchase of an electric breast pump*
- *A home nurse visit after delivery*
- *Access to NHP's quit-smoking counselor*
- *Access to mental health or substance abuse services*
- *Immunization information, schedules, and reminders*

NHP also provides reimbursement for childbirth classes. NHP will reimburse you up to $90 for a first time childbirth class and up to $45 for each refresher course. You must pay the full cost of the childbirth course. After you complete the course, you may file a Claim to NHP for reimbursement. For additional information, call NHP's Customer Care Center at 800-462-5449 or TTY 800-655-1761.

Pediatric Care Management

NHP's Pediatric Care Management program focuses on Members under age 19 who may have special health care needs. As a service to parents, this program coordinates a child's medical and Behavioral Health care and other needs. This program also links families to special resources and other programs that help children with special health care needs. NHP can also connect you to our Parent Consultant, the parent of a special needs child who can provide emotional support, as well as information about support groups, special education, and community resources.

Regional Care Management

If you require home health care, specialty outpatient services, acute hospitalization, rehab care, or care in a skilled nursing facility, care managers collaborate with health care Providers to coordinate your health care needs to ensure your needs are met.

Social Care Management

Neighborhood Health Plan has a team of Social Care Managers who have experience helping Members access community-based services and programs. A Social Care Manager can help you determine the types of programs you and your family may be able to access, such as:

- *Public assistance (cash benefits)*
- *Housing services*
- *Food programs*
- *Utilities assistance (gas, electric, or phone service)*
- *Services for people with disabilities*
- *Making appointments and finding transportation*

The Smoking Cessation (Stop Smoking) Program

NHP provides support for Members trying to quit smoking. Getting help from a smoking cessation counselor, using a Nicotine Replacement Therapy (NRT) program, or both, significantly improves your chances of quitting. A smoking cessation counselor can discuss issues such as deciding on a treatment option, choosing a quit day, dealing with urges when you really want a cigarette, and living with other smokers in your life who are not ready to quit. The program also includes free over-the-counter nicotine replacement therapy medication and educational materials. You will need to talk to your healthcare Provider to find out if NRT is right for you, and to get a prescription.

For more information about quitting smoking:

- *Call NHP's Quit Smoking Counselor: 617-204-1447;*
- *Call the Massachusetts Quitline: 800-TRY-TO-STOP; or*
- *E-mail our smoking cessation counselor at quitsmoking@nhp.org*

Section 12.
Member Rights and Responsibilities

Your Rights as an NHP Member

As a valued Member of NHP, you have the right to:

- *Receive information about NHP, our services, our providers and practitioners, your covered benefits, and your rights and responsibilities as a Member of NHP.*
- *Have your questions and concerns answered completely and courteously.*
- *Be treated with respect and with consideration for your dignity.*
- *Have privacy during treatment and expect confidentiality of all records and communications.*
- *Discuss and receive information regarding your treatment options, regardless of cost or benefit coverage, with your Provider in a way which is understood by you.*
- *Be included in all decisions about your health care, including the right to refuse treatment.*
- *Change your Primary Care Provider.*
- *Access Emergency care 24 hours/day, 7 days a week.*
- *Access an easy process to voice your concerns, and expect follow-up by NHP.*
- *File an Appeal (Grievance) or Complaint if you have had an unsatisfactory experience with NHP or with any of our contracted Providers or if you disagree with certain decisions made by NHP.*
- *Make recommendations regarding NHP's Member rights and responsibilities.*
- *Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.*
- *Freely apply your rights without negatively affecting the way NHP and/or your Provider treats you.*
- *Ask for and receive a copy of your medical record and request that it be changed or corrected.*
- *Receive the Covered Health Care Services you are eligible for as outlined in this Handbook.*

Your Responsibilities as an NHP Member

As a Member of NHP, you also have responsibilities. It is your responsibility to:

- *Choose a Primary Care Provider, the Provider responsible for your care.*
- *Call your Primary Care Provider when you need health care.*
- *Tell any health care Provider that you are an NHP Member.*
- *Give complete and accurate health information that NHP or your Provider needs in order to provide care.*
- *Understand the role of your Primary Care Provider in providing your care and arranging other medical services that you may need.*
- *Understand your health problems and take part in making decisions about your health care and in developing treatment goals with your Provider.*
- *Follow the plans and instructions agreed to by you and your Provider.*
- *Understand your benefits – what's covered and what's not covered.*
- *Call your Primary Care Provider within forty-eight (48) hours of any Emergency or out-of-area treatment. If you experienced a Behavioral Health (mental health and substance abuse) Emergency you should contact your Behavioral Health Provider, if you have one.*
- *Notify NHP and the GIC of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, etc.*

Reporting Health Care Fraud

If you know of anyone trying to commit health care fraud, please call our confidential Compliance Helpline at 1-800-826-6762. You do not need to identify yourself. Examples of health care fraud include:

- *Receiving bills for health care services you never received*
- *Individuals loaning their health insurance ID card to others for the purpose of receiving health care services or prescription drugs*
- *Being asked to provide false or misleading health care information*

Member Satisfaction

Our Customer Care Representatives want you to get the most from your NHP membership. Call us if you:

- *Have any questions about your NHP benefits*
- *Need help choosing a Primary Care Provider*
- *Receive a bill from a Provider, Primary Care Site, or hospital*
- *Lose your NHP Member Card*
- *Want to file a Grievance or make a Complaint*

In addition, please be sure to let NHP's Customer Care Center know if you:

- *Move*
- *Get a new telephone number*
- *Have a new addition to your family*

If You Receive a Bill in the Mail or If You Paid for a Covered Service

NHP Providers should not bill you for any service included in the description of Covered Health Care Services. But, if you receive a bill from a Provider, send a copy of the bill to NHP at the address given below. If you paid an NHP Provider for any service included on the Covered Health Care Services list you should contact NHP's Customer Care Center and NHP will arrange to have you reimbursed by the Provider. If you need Emergency or Urgent Care while traveling abroad or out-of-state, NHP will pay the Provider directly. Ask the Provider to contact NHP to discuss payment if the Provider asks you for money. If you do pay for Emergency or Urgent Care while traveling abroad or out-of-state, NHP will reimburse you. Please send a copy of the bill and proper receipts indicating payment to NHP at:

Neighborhood Health Plan
Attn: Customer Care Center
253 Summer Street
Boston, MA 02210-1120

Be sure to include the following information:

- *Member's full name*
- *Member's date of birth*
- *Member's NHP Member identification number*
- *Date the health care service was provided*
- *A brief description of the illness or injury*
- *For pharmacy items, you must include a dated drug store receipt stating the name of the drug or medical supply, the prescription number, and the amount paid for the item*

Limits on Claims

NHP will pay or reimburse you only for services that are Emergency or Urgent Care benefits. You must send any bills or receipts to NHP within twelve (12) months of the Date of Service. NHP is not required to pay bills or reimburse you for Claims received later than twelve (12) months after the Date of Service. NHP will pay or reimburse you only for services that are Covered Health Care Services and that are obtained in accordance with NHP policies.

Section 13.
Financial Obligations

As part of your contract you have certain financial obligations with respect to paying for covered health services.

In most cases, you will be asked to pay a Copayment when receiving a covered health care benefit, such as a visit to the doctor, a prescription or an admission into the hospital. Copayments are fixed dollar amounts that are due at the time the service is received or when billed by the provider. Your Benefit Summary identifies what your Copayment should be for various health care benefits. Unless you have a Deductible, you should not be asked to pay more than your Copayment amount for a covered health care benefit when it is provided by an NHP contracted provider.

Some plans require you to pay a Deductible. Your Benefit Summary indicates if you have any Deductible amounts. A Deductible is a specific annual dollar amount you must pay each year for certain services. You may have a Deductible for medical expenses, and a separate Deductible for pharmacy expenses. Once you meet your annual Deductible, you may still be responsible for Copayment amounts and any applicable coinsurance responsibilities. If you have an individual membership, you must pay the individual Deductible each year. A family Deductible is met when the combined Deductible payments for any covered family members add up to the total family Deductible amount. The most each member can contribute towards the family Deductible per year is equal to the individual Deductible amount. Your Deductible may be based on a calendar year or plan year. The calendar year begins on January 1 and ends on December 31 each year. A plan year, if applicable, is defined by your employer. Not all services apply to a Deductible. There are services that require a Copayment, those with no charge, and those that are subject to a Deductible. Copayments do not count toward your Deductible, but do count toward your Copayment maximum.

Some plans also provide coverage with coinsurance. If your coverage requires payment of coinsurance, the applicable coinsurance percentages are listed in your Benefit Summary. After you have met any applicable Deductible amount, you will be responsible for a specified percentage of the cost of a covered health care benefit you receive and NHP will be responsible for the remainder of the cost. The coinsurance for medical expenses is generally 20%, while the coinsurance for pharmacy expenses is generally greater than 20%.

Some plans have an Out-of-Pocket maximum dollar amount. Your Benefit Summary indicates if you have an Out-of-Pocket maximum. The Out-of-Pocket maximum represents the maximum amount you are required to pay each year for certain services.

In order to ensure that you are not held responsible for amounts in excess of your Copayments, deductibles, coinsurance or Out-of-Pocket maximums, your health care services, except as specified in this Handbook, must be provided by an NHP network provider; arranged by your PCP; authorized by NHP, if prior authorization is required, and that the services must be received during your active enrollment with NHP. Failure to ensure that all of these requirements have been satisfied may result in your being held financially responsible for the total cost of the service provided to you.

When seeing an NHP network provider you should never be asked to pay more than your Copayment, Deductible or coinsurance limits allow, as specified by your Benefit Summary. If you receive a bill from an NHP network provider that exceeds these allowed amounts please contact NHP Customer Care Center from Monday through Friday, 8:30 A.M. to 6 P.M. at 800-462-5449 (TTY 800-655-1761).

Section 14.
Notices

Confidentiality, Medicare Part D Notice of Creditable Coverage, HIPAA

Confidentiality

NHP takes seriously, our obligation to protect your personal and health information. To help in maintaining your privacy, we have instituted the following practices:

- *NHP employees do not discuss your personal information in public areas such as the cafeteria, on elevators or when out-side of the office.*
- *Electronic information is kept secure through the use of passwords, automatic screen savers and limiting access to only those employees with a "need to know."*
- *Written information is kept secure by storing it in locked file cabinets, enforcing "clean-desk" practices and using secured shredding bins for its destruction.*
- *All employees, as part of their initial orientation, receive training on our confidentiality and privacy practices.*
- *All providers and other entities with whom we need to share information are required to sign agreements in which they agree to maintain confidentiality.*
- *NHP only collects information about you that we need to have in order to provide you with the services you have agreed to receive by enrolling in NHP or as otherwise required by law.*

In accordance with state law, NHP takes special precautions to protect any information concerning mental health or substance abuse, HIV status, sexually transmitted diseases, pregnancy or termination of pregnancy.

NHP Notice of Privacy Practices

This section describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. Neighborhood Health Plan (NHP) provides health insurance coverage to you. Because you get health benefits from NHP, we have personal health information (PHI) about you. By law, NHP must protect the privacy of your health information.

This section explains:

- *When NHP may use and share your health information.*
- *What your rights are regarding your health information.*

NHP may use or share your health information:

- *When the U.S. Department of Health and Human Services needs it to make sure your privacy is protected.*
- *When required by law or a law enforcement agency.*
- *For payment activities, such as checking if you are eligible for health benefits, and paying your healthcare Providers for services you get.*
- *To operate programs, such as evaluating the quality of healthcare services you get, and performing studies to reduce healthcare costs.*
- *With your healthcare Providers to coordinate your treatment and the services you get.*
- *With health-oversight agencies, such as the federal Centers for Medicare and Medicaid Services, for oversight activities authorized by law, including fraud and abuse investigations.*
- *For research projects that meet privacy requirements, and help us evaluate or improve NHP programs.*

- *With government agencies that give you benefits or services.*
- *With plan sponsors of employer group health plans, but only if they agree to protect that information;*
- *To prevent or respond to an immediate and serious health or safety emergency.*
- *To remind you of appointments, benefits, treatment options or other health-related choices you have.*

When State privacy law is stricter than Federal privacy law, NHP will follow the stricter law.

For example, Massachusetts state law requires NHP to get your written permission before sharing sensitive information such as HIV/AIDS or drug abuse.

Except as described above, NHP cannot use or share your health information with anyone without your written permission. You may cancel your permission at any time, as long as you tell us in writing. Please note: We cannot take back any health information we used or shared when we had your permission.

You have the right to:

- *See and get a copy of your health information. You must ask for this in writing. NHP may charge you to cover certain costs, such as copying and postage.*
- *Ask NHP to change your health information if you think it is wrong or incomplete. You must tell us in writing which health information you want us to change, and why.*
- *Ask NHP to limit its use or sharing of your health information. You must ask for this in writing. NHP may not be able to grant this request.*
- *Ask NHP to get in touch with you in some other way, if by contacting you at the address or telephone number we have on file, you believe you would be harmed.*
- *Get a list of when and with whom NHP has shared your health information. You must ask for this in writing.*
- *Get a paper copy of this notice at any time.*

These rights may not apply in certain situations. By law, NHP must give you notice explaining that we protect your health information, and that we must follow the terms of this notice.

NHP can change how we use and share your health information. If NHP does make important changes, we will send you a new notice. That new notice will apply to all of the health information that NHP has about you.

NHP takes your privacy very seriously. If you would like to exercise any of the rights we describe in this notice, or if you feel that NHP has violated your privacy rights, contact NHP's Privacy Officer in writing at the following address:

Neighborhood Health Plan
Privacy Officer
253 Summer Street
Boston, MA 02210-1120

Filing a Complaint or exercising your rights will not affect your benefits. You may also file a Complaint with the U.S. Secretary of Health and Human Services at:

The U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Telephone: 202-619-0257
Toll Free: 877-696-6775

For more information, or if you need help understanding this notice, call NHP's Customer Care Center at 800-462-5449 or TTY 800-655-1761, Monday through Friday, 8:30 AM to 6:00 PM.

GIC Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

Payment activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures: The GIC may use and share PHI as follows:

- *To resolve complaints or inquiries made on your behalf (such as appeals);*
- *To verify agency and plan performance (such as audits);*
- *To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);*
- *For judicial and administrative proceedings (such as in response to a court order);*
- *For research studies that meet all privacy requirements;*
- *To tell you about new or changed benefits and services or health care choices.*

Required Disclosures: The GIC must use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- *Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.*
- *Ask the GIC amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.*
- *Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;*
- *Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.*
- *Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.*
- *Receive a separate paper copy of this notice upon request. (an electronic version of this notice is on our website at www.mass.gov/gic.*

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 801 or TTY for the deaf and hard of hearing at (617)-227-8583.

Notice of Your Prescription Drug Coverage and Medicare

The Centers for Medicare Services requires that this NOTICE OF CREDITABLE COVERAGE be sent to you. Please read it carefully and keep it where you can find it. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. This notice

- *Applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;*
- *Provides information about your GIC-sponsored drug coverage and the new Medicare*

drug coverage to help you decide whether to enroll in one of the Medicare drug plans;

- *Explains your options; and;*
- *Tells you where to find more information to help you make a decision.*

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NEW MEDICARE DRUG PLANS, SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

The new Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans might also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- *You can continue to receive prescription drug coverage through your GIC health plan rather than joining a new Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.*
- *Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.*
- *If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.*
- *If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan, Harvard Pilgrim Health Care First Seniority or Tufts Health Plan Medicare Preferred (formerly Secure Horizons), you will lose your GIC-sponsored health plan coverage under current Medicare rules.*
- *If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at 800-772-1213 (TTY 800-325-0778).*

Medicare Part D Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage will pay. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof of your having Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll.

After May 15, 2006, if your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll. For more information about this notice or your prescription drug coverage options:

- *Call 1-800-MEDICARE (1-800-633-4227 | TTY 1-877-486-2048).*
- *Visit www.medicare.gov*
- *Call the Group Insurance Commission at 1-617-727-2310.*

HIPAA Portability Rights Notice

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance (617-521-7777) or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272.

USING CERTIFICATES OF CREDITABLE COVERAGE TO REDUCE PRE-EXISTING CONDITION EXCLUSION WAITING PERIODS.

Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as 'pre-existing condition exclusions," apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date (an enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior 'creditable' coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare, and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage.)

When you have the right to specially enroll in another plan.

If you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees.

In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights.

Therefore, should you have such a life event or your coverage end, you should request special enrollment in another plan as soon as possible if you are eligible for it.

You have the right not to be discriminated against based on health status.

A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When you have the right to individual coverage.

If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a

pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- *You have had coverage for at least 18 months without a break in coverage of 63 days or more;*
- *Your most recent coverage was under a group health plan;*
- *Your group coverage was not terminated because of fraud or nonpayment of premium;*
- *You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.*

If you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

Uniformed Services Employment and Re-employment Rights Act: Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. To continue your existing health plan coverage contact the GIC.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions.

Section 15.
Complaint and Grievance Process

Neighborhood Health Plan tries to meet and go beyond what our Members expect of us. If an NHP experience did not meet with your expectations, we want to know about it so we can understand your needs and provide better service.

Complaints

Members have the right to voice concerns and file Complaints. If you file a Complaint, NHP staff will be courteous and professional, and all information about the Complaint will be kept confidential. Filing a Complaint will not affect your NHP coverage in a negative way.

To file a Complaint, call, write or fax the NHP Customer Care Center at 800-462-5449 or TTY 800-655-1761. Representatives are here to assist you Monday through Friday, 8:30 AM to 6:00 PM. Our offices are located at 253 Summer Street, Boston, MA 02210.

How the Complaint Process Works

A Customer Care Representative will ask for information about the Complaint, and, if possible, solve the problem over the telephone at the time of your call. If the Customer Care Representative cannot resolve the situation to your satisfaction at the time of your call, we will make every effort to resolve your Complaint within three (3) business days (called the Internal Inquiry Period). If we are unable to satisfactorily resolve your Complaint within three (3) business days, we will, at your request, continue to investigate and resolve the matter through our internal Grievance process.

Grievances

If you are not satisfied with the way NHP responded to your Complaint or with any decision made by NHP about your health care or service, you have the right to file a Grievance. A Grievance is a request that NHP reconsider a decision or investigate a Complaint regarding the quality of care or services that you have received or any aspect of NHP's administrative operations. If your Grievance is about a decision NHP has made to deny coverage of health care or services, you must file your Grievance within 180 calendar days of your being notified of the decision. Filing a Grievance will not affect your NHP coverage in a negative way. The time period for NHP to resolve your Grievance will begin either on the day after the Internal Inquiry Period, or at any time during the Internal Inquiry Period if you notify NHP that you are not satisfied with the response thus far to your inquiry. Time limits may only be waived or extended by mutual written agreement between you or an authorized representative and NHP. Any such agreement shall state the additional time limits, which shall not exceed fifteen (15) business days from the date of the agreement.

You may designate an authorized representative (a friend, relative, healthcare Provider, etc.) to act as your representative during the Grievance process. The authorized representative has the same rights and responsibilities as the Member.

Frequently Asked Questions about The Grievance Process

How do I file a Grievance?

You may file a Grievance by telephone, in person, by mail or by fax. NHP will send you a written acknowledgement of receipt of your Grievance within one (1) business day. If you telephone us, or stop by in person, your Grievance will be transcribed by NHP and a copy forwarded to you or your authorized representative within forty-eight (48) hours (except where this time

limit is waived or extended by mutual written agreement between you or your authorized representative and NHP). We request that you read, sign and return to NHP this written transcription of your oral Complaint. This helps to ensure that we fully understand the nature of your complaint. You may contact NHP in writing or by phone to initiate the Grievance process:

You may write:

Neighborhood Health Plan
Attn: Customer Care Center
253 Summer Street
Boston, MA 02210-1120
FAX: 617-526-1985

Or call the NHP Customer Care Center
Monday–Friday, 8:30 AM to 6:00 PM

800-462-5449
800-655-1761 (TTY)

How do I designate an Authorized Representative?

An Authorized Representative is anyone you choose to act on your behalf in filing a Grievance with NHP. An Authorized Representative can by a family member, a friend, a Provider or anyone else you choose. Your Authorized Representative will have the same rights as you do in filing your Grievance. Please note, however, that if you wish to choose an Authorized Representative you must sign and return a Designation of Authorized Representative Form to NHP. To obtain this form, please contact the NHP Customer Care Center.

What if my Grievance is about my health care or services?

If your Grievance pertains to a decision NHP has made about your health care or services, you or your authorized representative may be asked to sign and return a release of medical information to NHP. After receipt of all necessary releases, your medical information will be requested by NHP. You or your authorized representative will have access to any medical information and records relevant to the Grievance which are in the possession of NHP. If we requested that you provide us with a signed authorization and you (or your authorized representative) do not provide the signed authorization for release of medical information within thirty (30) calendar days of the receipt of the Grievance, NHP, may issue a resolution of the Grievance without review of some or all of the medical records.

What if my Grievance is about a behavioral health care service?

NHP has delegated the management of Grievances involving behavioral health or substance abuse services to Beacon Health Strategies. To initiate a Grievance with Beacon Health Strategies you may contact them in writing or by phone.

Appeals Coordinator
800-414-2120
781-994-7660 (TTY)

Beacon Health Strategies
500 Unicorn Park Drive
Woburn, MA 01801

If you prefer, you can request that Neighborhood Health Plan, instead of Beacon Health Strategies, review your grievance regarding a behavioral health or substance abuse service.

What if resolution of my Grievance does not require review of my medical records?

If resolution of your Grievance does not require review of your medical records, the Grievance resolution process will begin on the day immediately after the Internal Inquiry Period or sooner if you notify NHP that you are not satisfied with NHP's response during the Internal Inquiry Period.

Who will review my Grievance?

Grievances are reviewed by an individual or individuals who are knowledgeable about the matters at issue in the Grievance. Grievances

of Adverse Determinations will be reviewed by an individual or individuals that did not participate in any of the prior decisions regarding the matter of the Grievance. These individuals are actively practicing health care professionals in the same or similar specialty who typically treat the medical condition, perform the procedure, or provide the same treatment that is the subject of the Grievance.

How will the decision on my Grievance be explained?

When NHP sends you a written decision on your Grievance, we will include complete identification of the specific information considered and an explanation of the basis for the decision. In the case of a Grievance that involves an Adverse Determination, the written resolution will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will, at a minimum:

- *Identify the specific information upon which the adverse determination was based;*
- *Discuss the presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria;*
- *Specify alternative treatment options covered by Neighborhood Health Plan, if any;*
- *Reference and include applicable clinical practice guidelines and review criteria; and*
- *Notify you (or your authorized representative) of the procedures for requesting external review, including an expedited review and the opportunity to request continuation of services.*

When will I hear from NHP about my Grievance?

NHP will contact you in writing within thirty (30) calendar days with the outcome of your Grievance review, unless you and NHP agreed to an extension.

Continuation of Services During the Grievance Process

If the subject matter of the Grievance involves the termination of ongoing services, the disputed coverage or treatment will remain in effect, without liability to you, until you or the your authorized representative have been informed of NHP's decision provided that you have filed your grievance on a timely basis. This continuation of coverage or treatment applies only to those services which, at the time of their initiation, were approved by NHP and which were not terminated pursuant to an exhaustion of your benefit coverage.

Reconsideration

NHP may offer you (or your authorized representative) the opportunity for reconsideration of a Final Adverse Determination where relevant medical information was:

- *Received too late to review within the thirty (30) calendar-day time limit; or*
- *Not received, but is expected to become available within a reasonable time period following the written resolution.*

If you choose to request reconsideration, NHP must agree in writing to a new time period for review, but in no event greater than thirty (30) calendar days from the agreement to reconsider the Grievance. The time period for requesting external review begins the date of resolution of the reconsidered Grievance.

Expedited Grievance Review for Special Circumstances

If you or your health care provider believe your health, life, or ability to regain maximum functioning may be put at risk by waiting thirty (30) calendar days, you or your doctor can request an expedited Grievance review.

All requests for an expedited Grievance review, in which a treating physician certifies that the request is (1) medically necessary; (2) that a denial of coverage would create substantial risk or serious harm; (3) and that the risk of such harm is so immediate that services should not await the outcome of a standard appeal, will be granted. An expedited grievance will be reviewed and resolved within 48 hours of the request; in the case of Durable Medical Equipment in which the physician has described the immediate and severe harm that will result to the Member if such equipment is not provided within 48 hours, within the reasonable time period specified by the treating physician.

Expedited Grievance Review for Persons Who are Hospitalized

A Grievance made while a Member is hospitalized will be resolved as expeditiously as possible, taking into consideration the medical and safety needs of the Member. A written resolution will be provided before the Member's discharge from the hospital. During a Member's hospitalization, and only during hospitalization, a health care professional or a representative of the hospital may act as the Member's Authorized Representative without written authorization by the Member.

Expedited Grievance Review for Persons with Terminal Illness

When a Grievance is submitted by an insured with a terminal illness, or authorized representative, resolution will be provided to the insured or authorized representative within five (5) business days from the receipt of the Grievance. If the Expedited Review process affirms the denial of coverage or treatment to an insured with a terminal illness, NHP will provide the insured or the insured's authorized representative, within five (5) business days of the decision:

- *A statement, setting forth the specific medical and scientific reasons for denying coverage or treatment;*
- *A description of alternative treatment, services or supplies covered or provided by NHP, if any.*

In addition, if the Expedited Review process affirms the denial of coverage or treatment to an insured with a terminal illness, NHP will allow the insured, or the insured's authorized representative, to request a conference. The conference will be scheduled within ten (10) days of receiving a request from an insured; provided however that the conference shall be held within five (5) business days of the request if the treating physician determines, after consultation with NHP's medical director or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by NHP, would be materially reduced if not provided at the earliest possible date.

At the conference, NHP will permit attendance of the insured, the authorized representatives of the insured, or both. A representative of NHP, who has authority to determine the disposition of the Grievance, will conduct the review.

NHP's Obligation to Timely Resolution of Grievances

If NHP does not act upon your Grievance within the prescribed timeframes or the agreed upon extended time frame, the Grievance will be decided in your favor. Any extension deemed necessary to complete the review of your Grievance must be authorized by mutual written agreement between you or your authorized representative and NHP.

Independent External Review

If you are not satisfied with the final outcome of the Grievance review you receive, you have the right to apply for an independent external review with the Massachusetts Department of Public Health's Office of Patient Protection. The Office of Patient Protection provides an independent review of grievances not resolved at the health plan (NHP) level to your satisfaction. The External Review Organization will review the grievance to determine if the service or treatment in question is Medically Necessary and a Covered Benefit. The decisions of the External Review Organization are final and binding

You, or your authorized representative, are responsible to activate the External Review Process. To activate the review:

- *Complete and submit the required application to the Department of Public Health within forty-five (45) days of the receipt of NHP's Final Grievance decision;*
- *Submit applicable filing fees ($25.00) to the Department of Public Health (The Office of Patient Protection may waive the fee in cases of extreme financial hardship).*

You may contact the Office of Patient Protection at any time by calling 1-800-436-7757, by fax at 1-617-624-5046, or on the internet at www.state.ma.us/dph/opp.

Expedited External Review and Continuation of Coverage

You or your authorized representative may request to have your request for review processed as an expedited external review.

Any request for an expedited external review must contain a certification, in writing, from your physician, that delay in the providing or continuation of health care services that are the subject of a Final Adverse Determination would pose a serious and immediate threat to your health. If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek continuation of coverage for the terminated service during the period the review is pending.

Any such request must be made by the end of the second business day following receipt of the Final Adverse Determination.

The review panel may order the continuation of coverage or treatment where it determines that substantial harm to your health may result in the absence of such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage will be at NHP's expense regardless of the final external review determination.

For more information about your Grievance rights as a resident of the Commonwealth of Massachusetts, contact the Massachusetts Office of Patient Protection. You can contact the Office of Patient Protection (OPP) at any time by telephone at 1-800-436-7757, by fax at 1-617-624-5046, or on the internet at www.state.ma.us/dph/opp.

Section 16.
Advance Directives: Planning for Future Health Care

If you become unable to make decisions about your healthcare, a document called an "Advance Directive" can help. An Advance Directive is a statement, written by you, which tells your healthcare Provider what to do if you are not able to make decisions about your care. Advance Directives can be in several forms:

Health Care Agents and Proxies

In Massachusetts, if you are at least eighteen (18) years old and of sound mind (can make decisions for yourself) you may choose someone as your Health Care Agent (also called your Health Care Proxy). Your Health Care Agent is a person that can act for you if your healthcare Provider states in writing that you are unable to make your own healthcare decisions. You may choose a Health Care Agent by filling out a Health Care Proxy form. You can get a Health Care Proxy form from the Commonwealth of Massachusetts. Write to the following address and send a self-addressed, stamped envelope:

Commonwealth of Massachusetts
Executive Office of Elder Affairs
1 Ashburton Place, Room 517
Boston, MA 02108

Living Wills

A "living will" is the popular term for a document in which you describe the kinds of medical treatment you would agree to—or not agree to—if you were unable to make or communicate those choices yourself. A living will can help your Health Care Agent, Providers, or a court make decisions about your health care. However, a living will is not "binding" in Massachusetts. This means that your Health Care Agent and Providers are not required to follow the instructions in your living will. If you decide to write a living will, be as clear and specific as you can about your preferences for health care, and be sure that it expresses your wishes accurately and completely. For more information about living wills, please consult with an attorney.

Organ Donation Cards

You can also write down your wishes about organ and tissue donation by filling out an organ donor card. If you want to know more about organ/tissue donation, contact:

Organ Bank
One Gateway Center
Newton, MA 02158-2803
1-800-446-6362 | 1-800-446-NEOB

Major Disasters

NHP will try to provide or arrange for services in the case of major disasters. These might include war, riot, epidemic, public Emergency, or natural disaster. Other causes include the partial or complete destruction of NHP facility(ies) or the disability of service Providers. If NHP cannot provide or arrange services due to a major disaster, NHP is not responsible for the costs or outcome of its inability.

Section 17.
Utilization Management and Quality Assurance

Utilization Management

The mission of the Utilization Review program at NHP is to ensure the provision of the highest quality of health care to its Members. This is accomplished through a multidisciplinary team approach to advocate for optimum standards of patient health, education, and safety. Our commitment to providing quality care is consistently integrated with our goal to promote appropriate resource utilization. The Utilization Review program promotes the continuity of patient care through the facilitation and coordination of patient services to ensure a smooth transition for Members as they obtain the appropriate level and intensity of services, across the continuum of health care. The Utilization Review program continually evaluates the needs of NHP's Members and promotes enhancements and improvements to the program as well as to the care delivery system.

Adverse Determinations

Decisions made by NHP or a designated utilization review organization to deny, reduce, modify, or terminate an admission, continued Inpatient stay, or the availability of any other services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care or effectiveness are considered Adverse Determinations. Written notification of Adverse Determinations will include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and will, at a minimum:

- *Identify the specific information upon which the adverse determination was based;*
- *Discuss the presenting symptoms or condition, diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria;*
- *Specify alternative treatment options covered by NHP, if any;*
- *Reference and include applicable clinical practice guidelines and review criteria; and*
- *Notify you (or your authorized representative) of our internal grievance process and the procedures for requesting external review.*

NHP engages in prospective review, concurrent review with discharge planning and case management of Health Care Services as part of its Utilization Review Program.

Initial Determination (Prospective Review)

Decisions are made within two (2) working days of obtaining all necessary information, including any necessary evaluations and/or second opinions. Providers are notified of the decision within twenty-four (24) hours. Both providers and members are sent written notification of prospective approvals within two (2) working days of the initial notification and within one (1) working day for prospective denials.

Concurrent Review

Decisions are made within one (1) working day of obtaining all necessary information, including any necessary evaluations and/or second opinions. Providers are notified of the decision within twenty-four (24) hours. Both providers and members are sent written notification (including number of extended days/visits, next review date, total number of days/visits approved, and date of service initiation) of concurrent approvals and denials within one (1) working day of the

initial notification. Services subject to concurrent review are continued without liability to the member until the member has been notified of the decision.

Reconsideration

NHP offers a treating provider an opportunity to seek reconsideration of an Adverse Determination from a clinical peer reviewer in any case involving a prospective or concurrent review. The treating provider is informed of this opportunity within the written denial letter. The reconsideration process will occur within one working day of the provider's request and will be conducted between the Provider and an NHP clinical peer reviewer. If the reconsideration process does not reverse the Adverse Determination, the Member or provider, on behalf of the member, may pursue NHP's grievance process. The reconsideration process is not a prerequisite to NHP's grievance process or an expedited appeal. Members can call NHP's Customer Care Center at 800-462-5449 (TTY 800-655-1761) to determine the status or outcome of Utilization Review decisions.

Case Management

Case Management is for timely coordination of quality Health Care Services to meet an individual's specific health care needs while facilitating care across agencies and organizations (home health, skilled nursing, Hospitals are examples) and creating cost effective alternatives for catastrophic, chronically ill or injured Members on a case by case basis. Examples of circumstances where case management may be beneficial include organ transplantation, asthma, diabetes or major traumatic injury such as burns. In cases regarding behavioral health or substance abuse services, NHP has delegated Utilization Review to Beacon Health Strategies; Pharmacy to MedMetrics Health Partners, Inc.; and Harvard Vanguard Medical Associates for all HVMA Members.

Quality Assurance Program

Neighborhood Health Plan is committed to improving the health of its Members by providing the highest quality health care through the design, implementation and continuous improvement of the most appropriate and effective delivery systems. The scope of NHP's Quality Assurance Program includes:

- *Member satisfaction;*
- *Access to care and services;*
- *Continuity of care;*
- *Provider credentialing;*
- *Preventive health services;*
- *Patient safety; and*
- *Health care outcomes.*

Important Note: If you have a concern about the quality of care you have received by an NHP Network Provider or the Service provided by NHP, please contact the NHP Quality Services Department at 1-800-433-5556.

Development of Clinical Guidelines and Utilization Review Criteria

Clinical guidelines and Utilization Review criteria at NHP are developed with input from practicing physicians in NHP's Network and in accordance with standards adopted by national accreditation organizations.

NHP guidelines are evidence based, wherever possible, and are applied in a manner that considers the individual's health care needs.

NHP guidelines are reviewed biennially or more often as new drugs, treatments, and technologies are adopted as generally accepted medical practice.

Evaluation of New Technology

NHP strives to ensure that our Members have access to safe and effective medical care. With the rapid advancement of technology and pharmaceuticals, NHP has a process to evaluate new technology on a case-by-case basis as well as on a benefit level.

Decisions to approve the use of a new technology are based on the highest benefit and lowest risk to the Member.

NHP reviews and evaluates new and emerging technologies, including diagnostics, surgical procedures, medical therapies, equipment and pharmaceuticals to determine their safety and effectiveness. NHP uses information gathered from varied sources including peer reviewed scientific literature, policy statements from professional medical organizations, national consensus guidelines, FDA reviews, and internal and external expert consultants in its evaluation efforts. Additionally, NHP may analyze market trends and legal and ethical issues in its evaluations as appropriate. Technologies are selected for review based on actual or potential demand.

The Chief Medical Officer or Medical Director is responsible for making medical necessity decisions on urgent requests for new technologies that have not been evaluated and approved through NHP's technology assessment process. In making this decision, the Chief Medical Officer or Medical Director reviews any available literature and consults with internal and external expert consultants as needed.

New technologies are incorporated into the NHP benefit structure based upon the strength of the safety and efficacy evidence, market analysis and the relevance to the NHP membership.

Access and Utilization

Neighborhood Health Plan is accessible to members seeking information about the utilization management (UM) process and authorization requests and decisions from 8:30 – 5:30 Monday through Friday. You may call at 800-462-5449 or 617-772-5565, or fax at 617-772-5512. For after hour utilization management issues, you may leave a message or fax; these lines are available 24/7. All requests and messages left after hours will be retrieved the next business day.

NHP recognizes that underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, NHP promotes appropriate utilization of services. NHP's utilization management decisions are based only on appropriateness of care and service and existence of coverage. NHP does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does NHP provide financial incentives to UM decision-makers to encourage decisions that result in underutilization.

Section 18.
Glossary

Advance Directive

A written statement that tells a Provider what to do if an illness or accident takes away the Member's ability to make decisions about his or her healthcare.

Adverse Determination

A determination, based upon a review of information provided, by NHP or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued Inpatient stay, or the availability of any other services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care or effectiveness.

Authorization

An Authorization is a special approval by NHP for payment of certain services.

Authorized Representative

Any individual that NHP can document has been authorized by the Enrollee in writing to act on the Enrollee's behalf with respect to a Complaint or Grievance.

Beacon Health Strategies

The organization contracted by NHP to work in collaboration with the NHP Behavioral Health Department to administer NHP's Mental Health/Substance Abuse Program.

Behavioral Health

Mental health and substance abuse treatment.

Benefit

Benefits are specific areas of plan coverage, such as outpatient visits, hospitalization and so forth, that make up the range of medical services available to subscribers. Also, a contractual agreement, specified in an Evidence of Coverage, determining covered services provided by insurers to members.

Benefit Maximum

The maximum amount payable under the policy for each covered person for each benefit as stated in the Evidence of Coverage.

Benefit Summary

The Benefit Summary is a general description of your NHP coverage.

It also lists the Co-payment amount, if any, on services your policy covers. The Benefit Summary is not the same as the Member Identification Card (see Member Identification Card).

Claim

An invoice from a Provider that describes the services that have been provided for a Member.

Complaint

Any inquiry made by, or on behalf of, an insured to NHP or one of NHP's utilization management designees that is not explained or resolved to the Member's satisfaction within three business days of the inquiry.

Copayment

A fixed amount paid by an Enrollee for applicable services or for prescription medications at the time they are provided.

Coverage Date

The date medical coverage becomes effective for a particular Enrollee.

Covered Benefits/Covered Services

The services and supplies covered by NHP described in this Handbook.

Day

A calendar day (unless business day specified.

Deductible

The amount for which the insured is liable on each loss, injury, etc., before an insurance company will make payment

Disenrollment

The process by which a Member's NHP coverage ends.

Effective Date

The date on which an individual becomes a Member of NHP and is eligible for Covered Benefits.

Eligible Individuals

Eligible Individuals are individuals who have permanent residence in the NHP service area.

Eligible Employees include employees of a sole proprietorship, firm, corporation, partnership or association actively engaged in a business that is based within the NHP service area. Eligible employees may enroll in through their employer group if they:

- *Are actively employed by a qualified contributing or non-contributing Massachusetts employer; and*
- *Meet all employer eligibility requirements.*

Emergency

A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in placing the health of an enrollee or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman who is having contractions, an emergency also includes having an inadequate amount of time to effect a safe transfer to another hospital before delivery or a threat to the health or safety of the Member or her unborn child.

Employer Group

The Group Insurance Commission, the state agency with which NHP enters into an Agreement to provide health care Coverage for the GIC's eligible employees and their Dependents.

Enrollee

An Eligible Individual or subscriber enrolled in a health insurance plan offered by a Contracted MCO (such as NHP), either by choice of the Eligible Individual or through an employer group.

Enrollment

The process by which NHP registers Eligible Individuals and Employees for membership.

Enrollment Date

The first day on which NHP is responsible for providing Covered Services to an Enrollee.

Evidence of Coverage

The legal document, made up of this Handbook and the Benefit Summary, that sets forth the services covered by NHP, the exclusions from coverage, and the conditions of coverage for Members.

Family Planning Services

Services directly related to the prevention of conception. Services include: birth control counseling, education about Family Planning, examination and treatment, laboratory examinations and tests, medically approved methods and procedures, pharmacy supplies and devices, sterilization, including tubal ligation and vasectomy. (Abortion is not a Family Planning Service.)

Final Adverse Determination

An adverse determination made after an Enrollee has exhausted all remedies available through NHP's internal Grievance process.

Formulary

The schedule of prescription drugs approved for use which will be covered by the plan and dispensed through participating pharmacies.

Grievance

Any oral or written Complaint submitted to NHP that has been initiated by an Enrollee, or the Enrollee's Authorized Representative, concerning any aspect or action of NHP relative to the Enrollee, including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, quality of care and administrative operations.

Group Insurance Commission Contract

The Contract between the Group Insurance Commission and NHP that sets forth the obligations of the GIC and the terms of NHP coverage for GIC insureds.

Health Care Agent

The individual responsible for making healthcare decisions for a person in the event of that person's incapacitation.

Licensed Mental Health Professional

Includes a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor or a licensed nurse mental health clinical specialist.

Inpatient

Services requiring at least one overnight stay in a hospital.

Inquiry

Any communication by or on behalf of an Enrollee to NHP that has not been the subject of an Adverse Determination and that requests redress of an action, omission or policy of NHP.

Managed Care

A system of health care delivery that is provided and coordinated by a Primary Care Provider. The goal is a system that delivers value by providing access to quality, cost-effective health care.

Medically Necessary Services

Medically Necessary or Medical Necessity describes health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the Enrollee in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

Member

Any Individual or Employee enrolled in NHP.

Member Financial Responsibility

The member's financial responsibility, if any, for any premiums, Copayments, or deductibles.

Member ID Card

The card that identifies an individual as a Member of NHP. The Member Card includes the Member's identification number, Primary Care Site and information about the Member's coverage. The Member Card must be shown to Providers prior to receipt of services.

Neighborhood Health Plan or NHP

A Massachusetts licensed, not-for-profit Managed Care Organization (MCO) founded in 1986 by the Massachusetts League of Community Health Centers and the Greater Boston Forum for Health Action. NHP's mission is to provide accessible health care delivery systems, which are Member-focused, quality-driven, and culturally responsive to our Members' needs.

NHP Provider

A Provider who, under contract with NHP or a delegated entity, has agreed to provide health care services to insureds with an expectation of receiving payment, other than coinsurance, Copayments or deductibles, directly or indirectly from NHP.

NHP Treating Provider

See "NHP Provider"

Network

The group of Providers contracted by NHP to provide health care services to Members.

Out-Of-Pocket Maximum

Maximum amount of money that the insured must pay on his own before the insurance company will pay 100% for insured's healthcare expenses.

Payment of Premium

The amount of money paid to Neighborhood Health Plan by the subscriber (or on the subscriber's behalf by an employer) to cover the cost of health insurance.

Primary Care Doctor

A family practitioner or internist, selected by the Member or assigned by NHP to provide and coordinate a Member's health care needs.

Primary Care Provider (PCP)

A Primary Care Doctor or nurse practitioner selected by the Member or assigned by NHP to provide and coordinate a Member's health care needs. Other health care providers, such as a registered nurse, nurse practitioners, physician's assistants or nurse midwives, acting on behalf of and in consultation with a Primary Care Provider, may provide primary care services.

Primary Care Site

The locations where Primary Care Providers provide care to NHP Members. A Primary Care Site may be a health center, an outpatient department of a hospital, a physician group practice, or another setting.

Provider

A health care professional or facility licensed as required by state law. Providers include doctors, hospitals, laboratories, pharmacies, skilled nursing facilities, nurse practitioners, registered nurses, psychiatrists, social workers, licensed mental health counselors, clinical Specialists in psychiatric and mental health nursing, and others. NHP will only cover services of a Provider if those services are Covered Benefits and within the scope of the Provider's license.

Provider Directory

A book containing a list of NHP's affiliated medical facilities and professionals, including Primary Care Providers, Specialists and Behavioral Health Providers.

Routine Care

Care that is not Urgent or Emergency care. An example of Routine Care is physical exams.

Service Area

The geographical area within which NHP has developed a Network of Providers to provide adequate access to Covered Services. The NHP Service Area includes most communities in Massachusetts.

Specialist

A Provider who is trained and certified by the state of Massachusetts to provide specialty services. Examples include but are not limited to cardiologists, obstetricians and dermatologists.

Tier (or Provider Tiering)

The level of Copayment structure assigned to a Primary Care Provider site or select specialists, including Cardiology, Endocrinology, OB/GYN, and Gastroenterology. The tier assignment is based upon provider's combined quality/cost-effectiveness score as derived from the GICs Clinical Performance Improvement Initiative (CPII) data. There are three levels, including:

***Tier 1 (excellent),
**Tier 2 (good) or
*Tier 3 (standard).

Primary Care Provider sites or select Specialists with the highest combined quality/cost-effectiveness scores are assigned to ***Tier 1 (excellent). Primary Care Provider sites or

select Specialists with scores that fall within the middle range are assigned to Tier 2, and Primary Care Provider sites or select Specialists with standard scores are assigned to *Tier 3 (standard). Primary Care Provider sites or Specialists who have insufficient data for comparison are assigned to the **Tier 2 (good) copay level.

Urgent Care

Urgent Care is medical care required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe are not an Emergency but do require medical attention. Urgent Care does not include Routine Care.

Utilization Review

A set of formal review techniques designed to monitor the use of—or evaluate the clinical necessity, appropriateness or efficiency of—Covered Health Care Services, procedures, or settings. Such review techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Workers Compensation

Insurance coverage maintained by employers under federal law to cover employees' injuries and illnesses under certain conditions.